सत्यमेव जयते

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

COURSE MATERIAL FOR TRAINING IN DISTRICT PROGRAMME MANAGEMENT

OPHTHALMOLOGY SECTION
DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA, NEW DELHI-110011

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Released
20/12/94.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

COURSE MATERIAL FOR TRAINING

IN

DISTRICT PROGRAMME MANAGEMENT

Edited by

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Acknowledgement

I am thankful to all the contributors for giving their valuable time and support in giving the write-ups on various issues related to the Training on District Programme Management meant for District level Officials and District Programme Managers under the National Programme for Control of Blindness. I specially thank Dr. Hans Limburg and his colleagues for not only helping in publishing this book but also enthusiastically participating as resource persons in various training courses for DPMs. The book is being published out of funds made available by WHO for which I am grateful. This book has been expeditiously edited by Dr.D.Bachani and Dr. Hans Limburg and processing done by the staff of this Directorate particularly Mrs. Vandana Chadha.

Rachel Jose

(Dr. (Mrs.)R.Jose)

DDG(O)

Editorial

The strategies for implementing National Programme for Control of Blindness have been revised in the recent past. Establishment of District Blindness Control Societies throughout the country is an step towards decentralised management of the programme. This follows successful experimentation in pilot Districts. The post of District Programme Manager (Co-ordinator) is very crucial in the functioning of District Blindness Control Societies. As a step towards uniformity in imparting training to District Programme Managers, an attempt has been made to standardize course material through this module. We are thankful to all the contributors for sharing their experiences and giving write-ups on various issues which will go a long way in making such training courses useful endeavours. The contents of this book are not official, but views of the contributors. Clarifications can be sought from the editors on any issues related to functioning of DBCS.

HANS LIMBURG

D.BACHANI

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MAGNITUDE OF BLINDNESS

Hans Limburg

Definition of Blindness:

The World Health Organisation defines blindness as Visual Acuity of less than 3/60 in the better eye with the **best possible** correction.
In India, under the National Programme for Control of Blindness (NPCB), blindness is defined as Visual Acuity of less than 6/60 in the better eye with the **usual** correction. This means, that in practice, absence of correction is considered an ophthalmological problem in India.

Visual Acuity is the sharpness of vision, measured as the maximum distance at which a person can see a certain object, divided by the maximum distance at which a person with normal eyesight can see the same object.

W.H.O	VISUAL ACUITY		INDIA
Category of Visual Impairment	Cannot See	Can See	Category of Visual Impariment
Low Vision (1)	6/18	6/60	Low Vision
Low Vision (2)	6/60	3/60	Economic Blindness
Blindness (3)	3/60	1/60	Social Blindness
Blindness (4)	1/60	Perc. Light +	Manifest Blindess
Blindness (5)	PL -	PL -	Absolute Blindness

It is important to realise the differences in definitions when comparing blindness data of India with other countries. In India the group with VA better than 3/60 but equal to or less than 6/60 is graded as "Blind", while WHO grades it as "Low Vision".

There are different ways to estimate the magnitude of blindness in a certain area or community. One can look at hospital records, diagnoses of eye diseases at the OPD as well as in-patients, eye camp records, earlier studies etc.
It is also possible to make a more accurate estimate of the number of blind persons at a particular point in time (=prevalence), and express the same as a percentage, through a survey. However, conducting an accurate and reliable survey is a complicated, expensive and time consuming exercise. Two major surveys have been conducted in India and they provided data on causes and prevalence of blinding disorders in India: one by the Indian Council for Medical Research in 1971 and one by WHO-NPCB in 1986. The findings of both these surveys are given in the figure in Annexure 1.

The first observation is that the prevalence of blindness in India has increased from 1.38% in 1971 to 1.49% in 1986.

Secondly, the blindness due to cataract has increased from 75% in 1971 to 81% in 1986.

Blindness due to Smallpox, Trachoma and Vitamin A deficiency have gone down. Smallpox as a disease is eradicated. Trachoma has decreased because of better water supply, better hygiene and availability of antibiotic eye drugs. Vitamin A deficiency went down because the Green Revolution made more food available.

However, it must be realised that these prevalence figures give the average for entire India. There are areas where Trachoma and Vitamin A deficiency are still highly prevalent today and certainly do need intervention.

The WHO-NPCB Survey of 1986 indicates that blindness is more common in rural than in urban areas, more in females than in males, more amongst the poor than amongst the rich. The main explanation for this lies in the availability, accessibility and affordability of eye care services. There are many more eye care facilities in urban than in rural India.

Main causes of Blindness in India:

Cataract:

Cataract is generally defined as any opacity of the crystalline lens of the eye. These lens opacities reduce the light rays falling on the retina and thereby blocks the vision. It is most commonly seen in elderly persons, and therefore also called 'senile' cataract. The older the person, the higher the risk of developing senile cataract. The causes of senile cataract are unknown. There are indications that this cataract develops more after severe dehydration, more in persons exposed to bright sunlight, more in people who smoke, more in patients with diabetes.
Cataract may also develop after injury to the eyeball or lens.
A different form of cataract can develop at a very young age, the congenital cataract.

Cataract can only be cured by surgical removal of the clouded lens. Removal of the lens causes a Refractive Error, which can be corrected by spectacles, contact lenses or a small plastic lens implanted in the eye, an Intra-Ocular Lens (IOL).

Why has cataract blindness increased so much?

First of all, demographic changes have been dramatic over this period. The number of persons above 40 years of age in India has increased from 115 million in 1971 to 187 million in 1991. In absolute figures, this is an increase of 63% of the population at risk.

Life expectancy at birth has also increased from 46 years in 1971 to 59 years in 1990. This risk to develop cataract blindness in India rises sharply above the age of 45

(Anexure 2). The increase of the number of persons at risk is the main reason of the increase in cataract blindness.

The number of operations performed annually in India has been increasing steadily between 1981 and 1986 from 0.5 million to 1.2 million. Thereafter it reached a plateau and only after 1990 there has been a further increase to nearly 2 million operations in 1993. (Annexure 3)

However, 2 million operations per year is not even enough to take care of the new cases of cataract blindness, which are added every year (=incidence). This incidence of new cases of cataract blindness is estimated at around 2 million persons per year. Despite the increase in cataract surgery over the last 15 years, the prevalence of cataract blindness is still increasing.

One should also realise that cataract operation done is not equal to sight restored. Not all cataract operations convert a blind person into a sighted person. The success rate of cataract surgery in India ranges from 85-95%. Patients blind in only one eye, therefore by definition not blind persons, are operated, second eyes are operated and also patients with a VA better than 6/60 are operated and provided with Intra-Ocular lenses (IOLs).It is estimated that at least 5 million cataract operations per year will be required to control cataract blindness in India. (Annexure 4)

- Refractive Errors:

In the normal eye, the lens focusses light to form a sharp image on the retina, the sensory tissue of the eye. When somebody has a Refractive Error, the lens is either under or over refracting the light rays and no sharp image is projected on the retina. This can be corrected by putting spectacles in front of the eye or contact lenses on the cornea.

Refractive Errors are most common in children between 8-15 years, middle age persons and elderly persons who have their lens removed because of cataract (aphakia).

Patients can be treated by measuring the power of the correction needed (refraction) and provision of glasses.

- Glaucoma:

In glaucoma, the pressure inside the eyeball is too high. This causes permanent damage to the optic nerve and sensory tissue of the retina. It can present in different clinical forms. Some cause acute pain in the eye, others are without any symptoms and gradually reduce the vision. Patients should be identified at an early stage, so that adequate treatment can prevent any further damage.
Treatment is medical or surgical.

- Vitamin A Deficiency (Xerophthalmia):

Adequate intake of Vitamin A is essential for the proper development of the retina,

as well as the superficial cell structures of the cornea, the skin, the lungs and the intestines. The earliest effects of Vitamin A deficiency involve the eye. It results in night blindness, dryness of the conjunctiva and cornea and ultimately in corneal ulceration, perforation and blindness.
It may also result in respiratory tract infections and diarrhoea. It is often related to protein-calory malnutrition, diarrhoea, worm infestations and other intestinal disorders. Blinding malnutrition mostly affects children between 6 months and 6 years of age.

Prevention is the most important intervention. Primarily, there should be an adequate intake of Vitamin A in the diet (breast milk, dark green leafy vegetables, mango, papaya, dairy products, fish, etc.). Where such dietary intake is not available, like in drought stricken areas, poverty, etc., 6 monthly administration of massive doses of Vitamin A to children from 6 months to 6 years can be a short term intervention.

- Trachoma:

Trachoma is a chronic infection of the eye, leading to red, rough and thickened membranes covering the inside of the eyelid and to opacity of the cornea. Scarring of the eyelid may cause an inward deviation of the eyelashes (entropion and trichiasis), which scratch over the cornea and cause ulceration, leading to scarring and visual loss. The infection is caused by Chlamydia Trachomatis.
The infection used to be widely spread in India. It is related with crowding of people, availability of safe water for household use, general hygiene and a dry and dusty environment. Due to improved hygiene, increased availability of safe water and availability of antibiotic eye ointments throughout India, Trachoma has drastically reduced to some small pockets only.

Intervention programmes are based on mass application of local antibiotics, especially to the young children, the adequate supply of safe water and improvement of hygiene. Entropion and trichiasis need surgical correction to prevent any or any further damage of the cornea.

Eye Injuries:

In India, eye injuries are a major cause of, usually uni-ocular, blindness. Most injuries occur in agriculture, small scale industries, in or around home, from automobile accidents and from potentially dangerous toys, sticks, fireworks or missiles.

The main intervention is prevention. This can be done through education on eye safety in schools and at work. Measures to increase occupational safety at work have to be implemented.

Adequate treatment facilities should be available at areas with increased risk, like certain industries, mines, etc.

EXERCISE 1:

Analyse the blindness problem in an average district by calculating the actual number of persons blind, due to different causes, in this district.

	URBAN		RURAL	
	%	Persons	%	persons
population as per 1991 census:	25%	500,000	75%	1,500,0000
prevalence of blindness	1%	.....	1.5%	.....

CAUSES OF BLINDNESS:

Cataract	80%	.....	80%	.....
Refractive Errors	7%	.....	7%	.....
Corneal Scar	4%	.....	4%	.....
Glaucoma	2%	.....	2%	.....
Vitamin A deficiency	1%	.....	1%	.....
Others	5%	.....	5%	.....
Incurable Blindness	10%	.....	10%	.....
New Cases / year	20%	.....	20%	.....

For calculating the data for your own district, follow the same procedure, using your district population and the prevalence figures from your state, as given in the Status Report NPCB.

EXERCISE 2

EXAMPLE 1:

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
NEW CASES		4,000	4,100	4,200	4,300
OLD CASES	(+)------	(+)------	(+)------	(+)------	(+)------
TOTAL CASES	24,000				
SIGHT RESTORED	500	1,000	1,500	1,700	2,000
EXPIRED	2,000	2,000	2,000	2,000	2,000
	(-)------	(-)------	(-)------	(-)------	(-)------
BACKLOG					

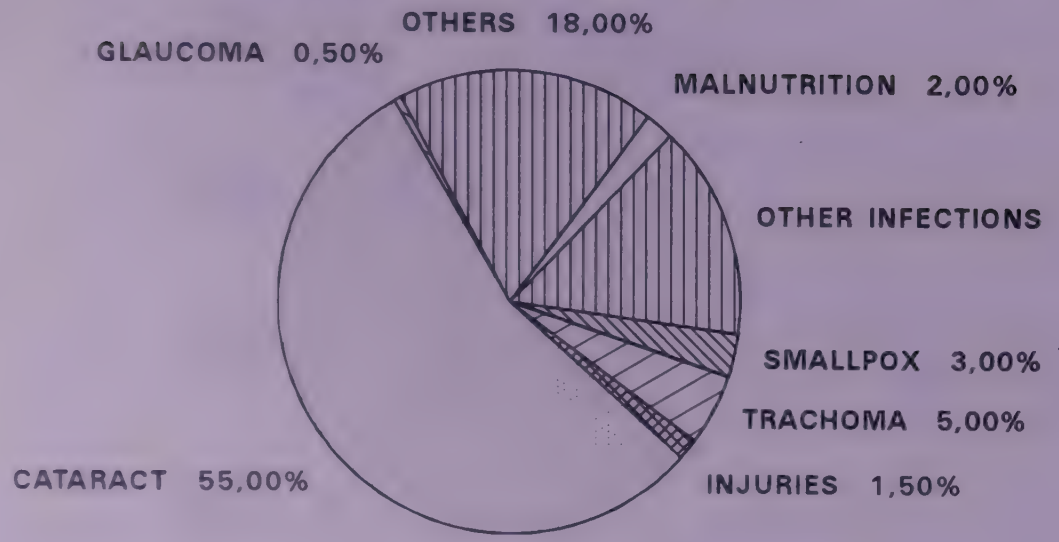
EXAMPLE 2:

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
NEW CASES	4,000	4,100	4,200	4,300	
OLD CASES	(+)------	(+)------	(+)------	(+)------	(+)------
TOTAL CASES	24,000				
SIGHT RESTORE	1,500	2,500	4,000	4,500	5,000
EXPIRED	2,000	2,000	2,000	2,000	2,000
	(-)------	(-)------	(-)------	(-)------	(-)------
BACKLOG					

Please be aware that "operation done" is not the same as "sight restored". In eye camps, the Sight Restoration Rate may be around 60%, which means that out of 100 cataract operations done, 60 persons have their eyesight restored. The other 40% may have been "second eyes", patients with other causes of blindness besides cataract and surgical failures. Only the patients with eyesight restored after the operation can actually be removed from the prevalence.

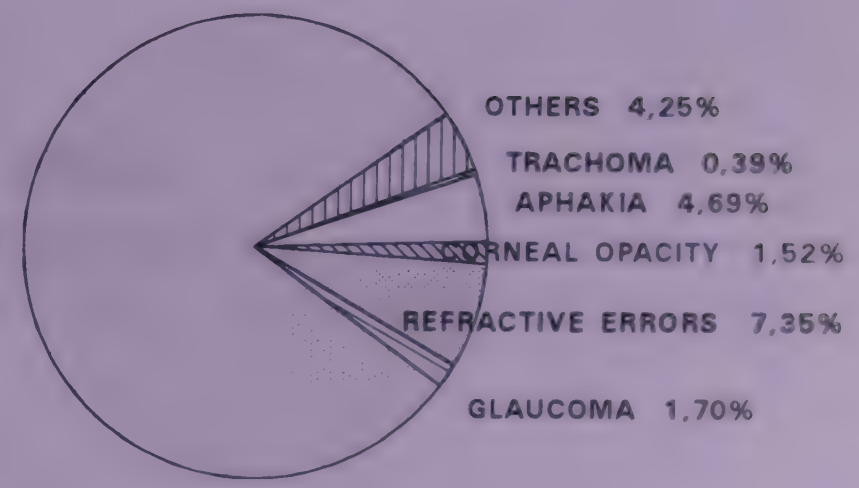
MAJOR CAUSES OF BLINDNESS IN INDIA

ICMR (1971)



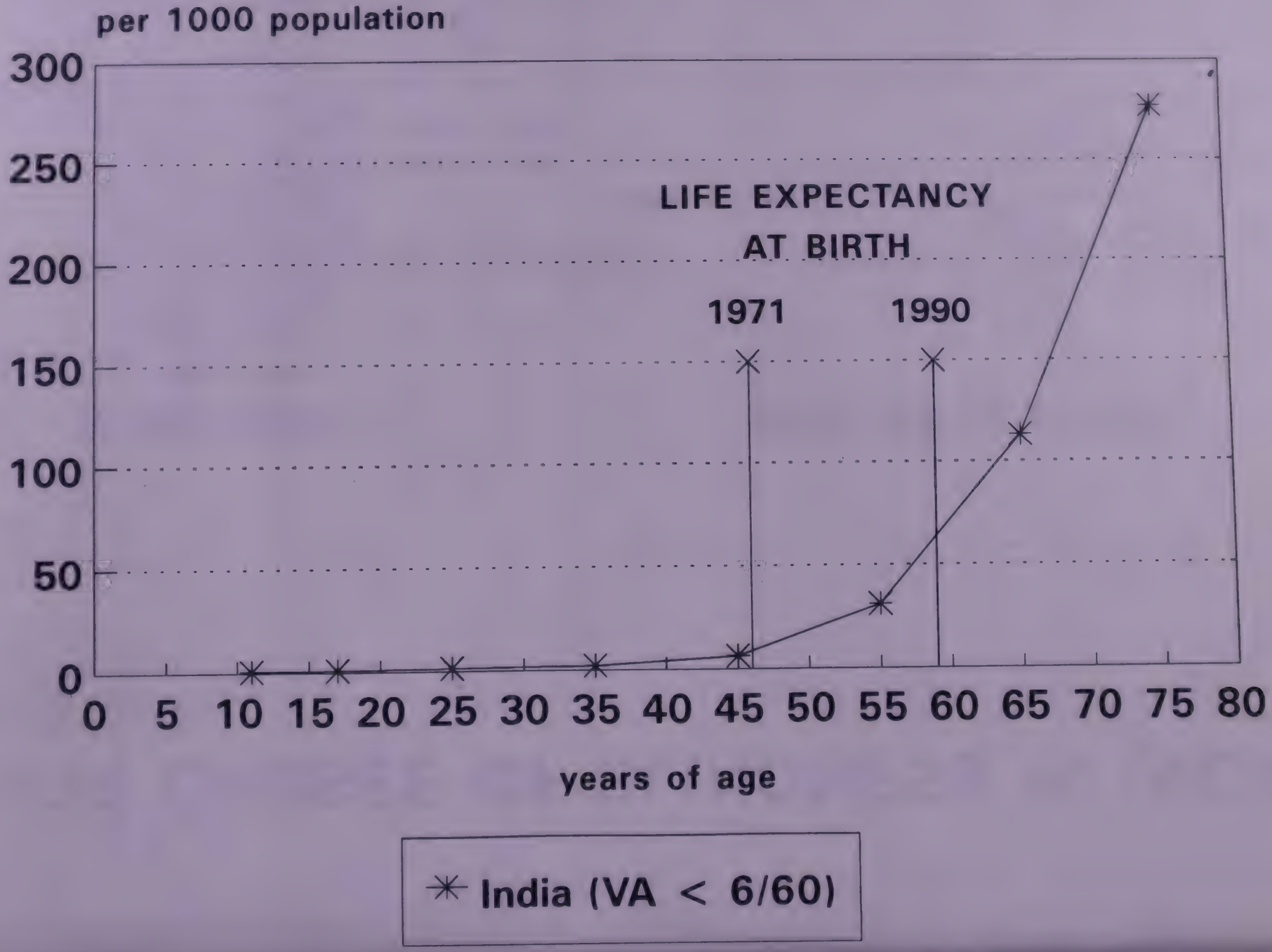
PREVALENCE (VA < 6/60):1.38%

WHO-NPCB (1986)

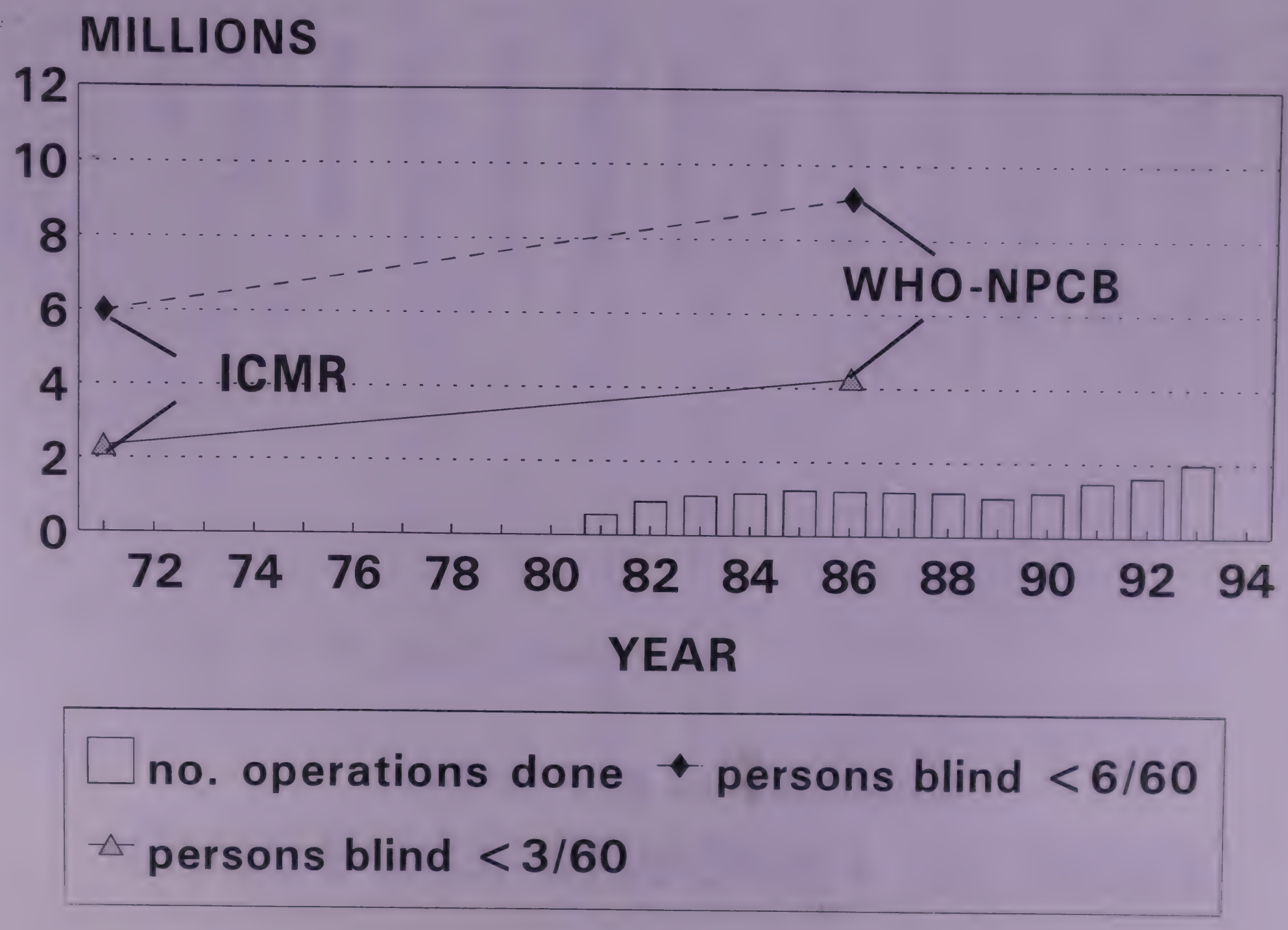


PREVALENCE BLINDNESS (VA < 6/60):1.49%

AGE SPECIFIC PREVALENCE RATES OF CATARACT BLINDNESS
(ICMR study 1971-1974)

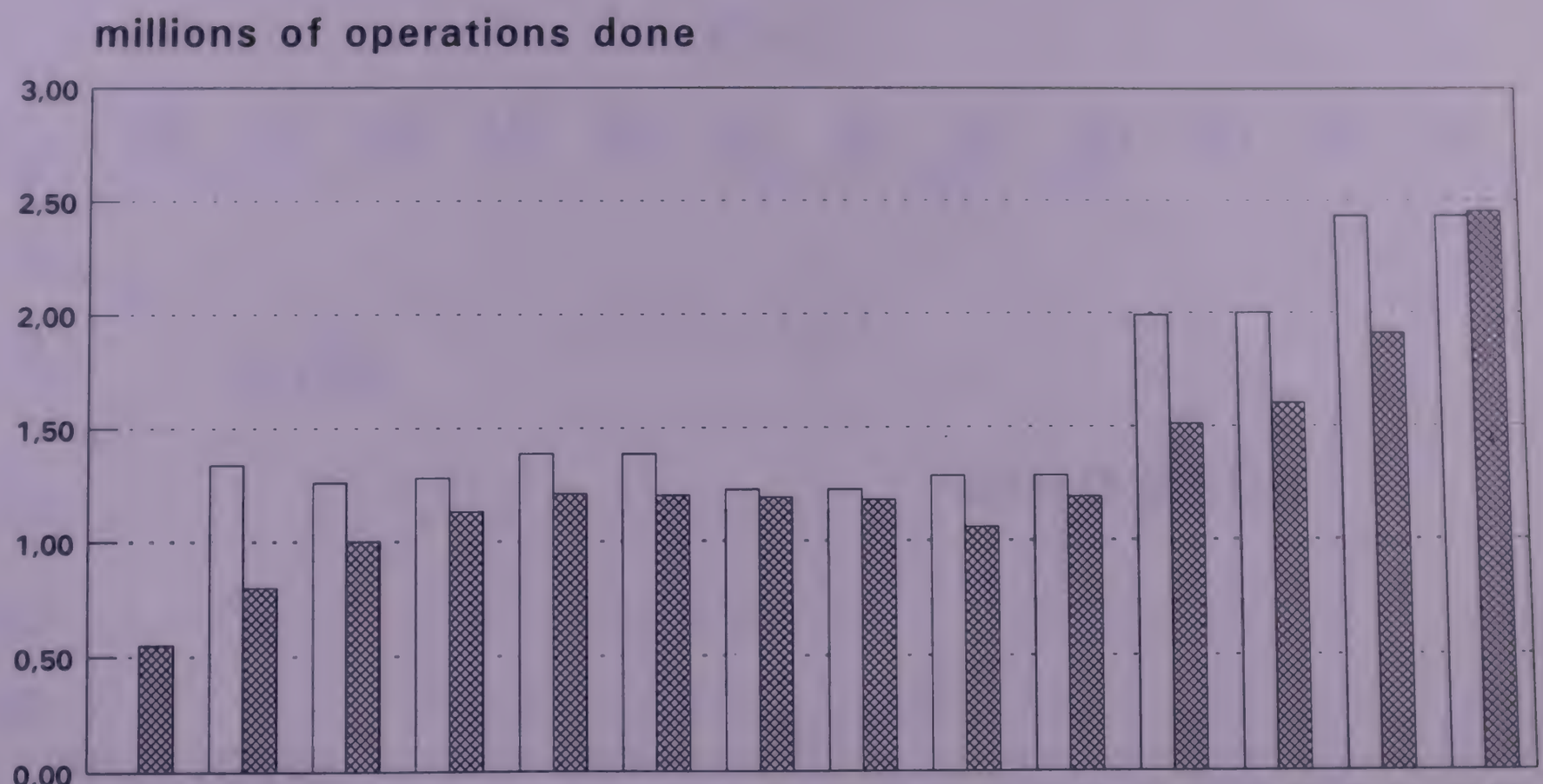


CATARACT BLINDNESS IN INDIA
prevalence and performance



CATARACT SURGERY IN INDIA

targets and performance



Target		1,34	1,26	1,28	1,38	1,38	1,23	1,23	1,28	1,28	1,99	2,00	2,43	2,43
Performance	0,55	0,80	1,00	1,13	1,21	1,20	1,19	1,18	1,06	1,19	1,51	1,60	1,91	2,45

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS:

RACHEL JOSE
DAMODAR BACHANI

With the launching of the National Programme for Trachoma in 1963, the first organised efforts to Control Blindness at National level commenced. This programme, without any major changes, was in operation for a decade. It was only in 1973-75, after the Indian Council of Medical Research survey results were received that the magnitude of the blindness problem was fully realised and the causes of blindness came into focus. The thrust of the strategies of the programme underwent extensive modifications as a result of this. The Central Council of Health and Family Welfare, at its meeting held in 1975, resolved that '*one of the basic human rights was the right to see and, therefore, it had to be ensured that no citizen goes blind needlessly; or being blind does not remain so, if, by reasonable deployment of skill and resources, his eye sight could be prevented from deteriorating and if already lost could be restored*'. Following this, the strategy evolved for prevention and control of blindness included:

(1) dissemination of information about eye care through mass communication with particular emphasis on ocular health among children and other vulnerable groups;

(2) augmentation of ophthalmic services in a manner that relief can be given to the community in the shortest possible time; and

(3) establishment of a permanent infrastructure of community oriented eye health care.

Based on the recommendations made by the Central Council of Health and given the new thrust areas, the National Programme for Trachoma was renamed as the National Programme for Prevention of Visual Impairment and Control of Blindness in 1976.

THE PROGRAMME AND ITS GOALS

National Blindness Control Programme was launched in the year 1976 as a 100 % centrally sponsored programme. Various activities of this programme include establishment of Regional Institutes of Ophthalmology, upgradation of medical colleges and district hospitals, development of mobile eye units, recruitment of required ophthalmic manpower and provision of various ophthalmic services. National survey was conducted, during the period 1986-89, to evaluate the programme. The prevalence of blindness revealed by the survey was 1.49 %. The activities under this programme are yet to show an impact in reducing the prevalence of blindness to the goal level of 0.3 % by the year 2000 A.D.

STRATEGY: The four pronged strategy of the programme is:

a) strengthening service delivery,
b) developing human resources for eye care,
c) promoting outreach activities and public awareness and
d) developing institutional capacity.

a) Strengthening Service Delivery

The programme aims to improve the physical, technical and managerial capabilities of medical colleges, district hospitals, community health centres, primary health centres and selected non-profit institutions to provide high quality cataract treatment in situ or through camps. The programme is implemented through a combination of service delivery models: medical colleges, base hospitals, camps in fixed facilities, camps in improvised facilities (in exceptional cases) and if necessary in private facilities, in collaboration between the Central Govt., the State governments, non-governmental organisations. Strengthening of service delivery is ensured through:

1. Adhering to the norms for service delivery
2. Increasing the output of resources allocated
3. Regularisation of organisation of camps
4. Involvement of NGOs and private sector:
5. Expansion of coverage to tribal & remote rural areas

b) Human Resources Development

This programme intends to strengthen medical colleges and RIOs to train ophthalmological and selected health personnel on cataract diagnosis; screening, surgery (ECCE/IOL and ICCE) and follow up care as required, and it would provide management training for Central and State project managers, District Society members, Project Coordinators and other project staff requiring managerial and administrative skills training.

c) Promoting Outreach Activities & Public Awareness

Beneficiary assessment have revealed a variety of factors deterring potential patients from seeking surgery in the different areas. The programme aims to generate patient demand for surgery through outreach camps and promotional campaigns.

d) Institutional Development

i) Developing institutional capability for eye care management at the Central, State and District levels.

ii) Developing collaborating mechanisms for cooperation between the Govt. and the private/voluntary sector.

iii) Introducing, monitoring and feedback mechanisms to facilitate implementation and maintain quality control.

iv) Building institutional capacity for human resources development.

ACHIEVEMENTS

Infrastructure Development

Tertiary level

At the tertiary level of ophthalmic care there are Regional Institutes of ophthalmology including the Apex institute that is, Dr. R.P. Centre in the All India Institute of Medical Sciences, New Delhi. These centres have been established as centres of excellence in the field of eye care. In addition, many medical colleges have been upgraded under NPCB. There are medical colleges which have been designated as training centres for Paramedical Ophthalmic Assistants. Eye banks have been developed in government and non-government sector for promotion of eye donation and collection of eyes for corneal transplantation.

Secondary level

Districts Hospitals have been equipped for ophthalmic services under NPCB. These districts have been given ophthalmic equipments and requisite manpower have been posted.

Recently, the concept of District Blindness Control Societies has been successfully implemented in five pilot districts. Based on the success, the scheme has been extended to cover the entire country. These societies have multi- disciplinary structure in which representatives of Government, non-government and private sector are members. The concept of District Blindness Control Society (DBCS) is to de-centralise management of ophthalmic services and evolve a partnership among Government, non-government and private sector.

Primary level

The problem of blindness is acute in rural areas and hence the programme has tried to expand accessibility of ophthalmic services. There are central mobile units (attached to medical colleges) and district mobile units which cater mobile eye camps for eye care in general and performance of cataract surgery in particular. These units have a vehicle, ophthalmic surgeon and other para medical staff. Most of the cataract operations in rural population are conducted through these mobile camps.

Primary health centres are the basic units in the rural areas. Primary health centres have been equipped with ophthalmic equipments and by posting para medical ophthalmic assistants.

Performance:

There are various activities under NPCB like general eye care, cataract surgery, correction of refractive errors etc. But the basic indicator to evaluate NPCB has been traditional performance in relation to cataract operations. There has been a gradual rise in the cataract operations performed from 5.5 lakhs in the year 1981-'82 to 11.34 lakhs in the year 1984-'85. However, after 1985 there has been a plateau in the performance between 11 to 12 lakhs operations till the year 1990-'91. There was sharp rise during the year 1991-'92 when more than 15 lakh operations were reported by various states.

Year	Operations (Lakhs)
1981-'82	5.50
1982-'83	8.04
1983-'84	10.49
1984-'85	11.34
1985-'86	12.19
1986-'87	12.09
1987-'88	11.96
1988-'89	11.85
1989-'90	10.69
1990-'91	11.97
1991-'92	15.12
1992-'93	16.05
1993-'94	19.12 (Provisional)
1994-'95	24.50 (Target)

Budget

Budgetary allocations for NPCB has remained more or less static. Budget released since 85-86 is as follows:

Year	Rs. in crores
1985 - 86	6.16
1986 -'87	5.56
1987 -'88	6.05
1988 -'89	5.44
1989 -'90	5.70
1990 -'91	5.67
1991 -'92	9.70
1992 -'93	19.90
1993 -'94	19.70
1994 -'95	40.00 (allocated)

International Assistance

The programme has been receiving assistance from Danish International Development Agency (DANIDA).It has been assisting in supply of equipments and

vehicles, improving the management information system, training and development of district blindness control societies. This assistance likely to continue through 1996.

A World Bank Assisted Cataract Blindness Control project has been initiated to boost up the activities of the programme in seven major States of the country namely Andhra Pradesh, Madhya Pradesh, Maharashtra, Tamilnadu, Orissa,Uttar Pradesh, Rajasthan. It is proposed to perform 1.1 Crore cataract operations during the project period 1994-2001. Major inputs of the Project are upgrading the ophthalmic services, expanding the coverage in rural and tribal areas, establishment and functioning of DBCS, training of ophthalmic manpower, improving the management and information system and creating awareness about the programme in the masses.Cooperation of non govt. and private sector is also envisaged in the project.The proposed expenditure of the Project is Rs 554 Crores during the Project period.

ORGANIZATIONAL STRUCTURE FOR N.P.C.B.

Organisation at the National Level

The National Programme for Control of Blindness (NPCB) is managed by the Directorate General of Health Services, Nirman Bhawan, New Delhi.

The Director General of Health Services (DGHS), is assisted by an Additional DGHS and a Deputy DG (DDG). The DDG is the National Programme Officer and is directly responsible for the programme at the National level. He/she is assisted by Assistant Director General and other officials.

The administrative wing is in the Ministry of Health and Family Welfare (Department of Health). Additional Secretary and Joint Secretary looks after the programme and is assisted by Deputy Secretary and/or Under Secretary.

Organisation at the State Level

Unlike at the National level, there are no designated Executive officers for the programme in the States. The responsible officer is the State Programme Officer who is a Joint/Deputy Director level officer supervised by the State Director of Health Services under the overall charge of the State Health Secretary. The State Programme Officer (NPCB) is assisted by a Statistical Assistant and other support staff. The functions of the State Programme Officer include implementation and monitoring of the programme in all the districts of the state.

Central Mobile Units allocated to the Ophthalmology Departments of the Medical Colleges, report to the Director of Medical Education. The training of Paramedical Ophthalmic Assistants (PMOAs) is carried out in the designated Medical Colleges, where these training schools are located.

Organisation at the District Level

There are two wings of service delivery at the district level - District hospital headed by a Medical Superintendent and Health programmes headed by the Chief Medical Officer (called District Health Officer in some States).

Each District Hospital has at least one Ophthalmologist posted for clinical and surgical work. Wherever the District Mobile Unit exists, it is attached to the District Hospital. The Ophthalmologist attached to the Mobile Unit is responsible for the eye camp activities.

The Chief Medical Officer/District Health Officer is the administrative incharge of the Community Health Centres (CHCs) and the Primary Health Centres (PHCs), where the Ophthalmic Assistants are posted. Unlike programmes like Family Welfare, Tuberculosis, Leprosy, Immunization and Malaria, there is no separate Programme officer for NPCB at the district level. This has resulted into absence of any focal authority for the programme at the district level, which has now been realised as an important managerial deficiency in the programme implementation. The Ophthalmic Surgeon has no administrative authority over the ophthalmic assistants (except in Maharashtra and Gujarat) and as such is unable to coordinate the activities in the district on his own. This has been addressed to by creating the DBCS and posting a full time District Programme Manager (Coordinator) to manage the activities of the Society.

Organisation at Subdistrict Level

At block level, an Ophthalmic Assistant is posted to work under the overall supervision of the Medical Officer Incharge. This is the last level where a designated worker for eye care has been provided in the health system. Further implementation at village level is expected to be carried out through the Health Workers and other community based workers/volunteers.

The programme structure at the Central, State, District and Sub-District levels indicates that Blindness Control is a vertical health programme with no effective penetration into the rural and tribal communities. It is essential to broaden this approach by the DBCS by involving other health functionaries and other sectors, NGOs and Private Practitioners, so as to make an effective network in the rural and tribal areas.

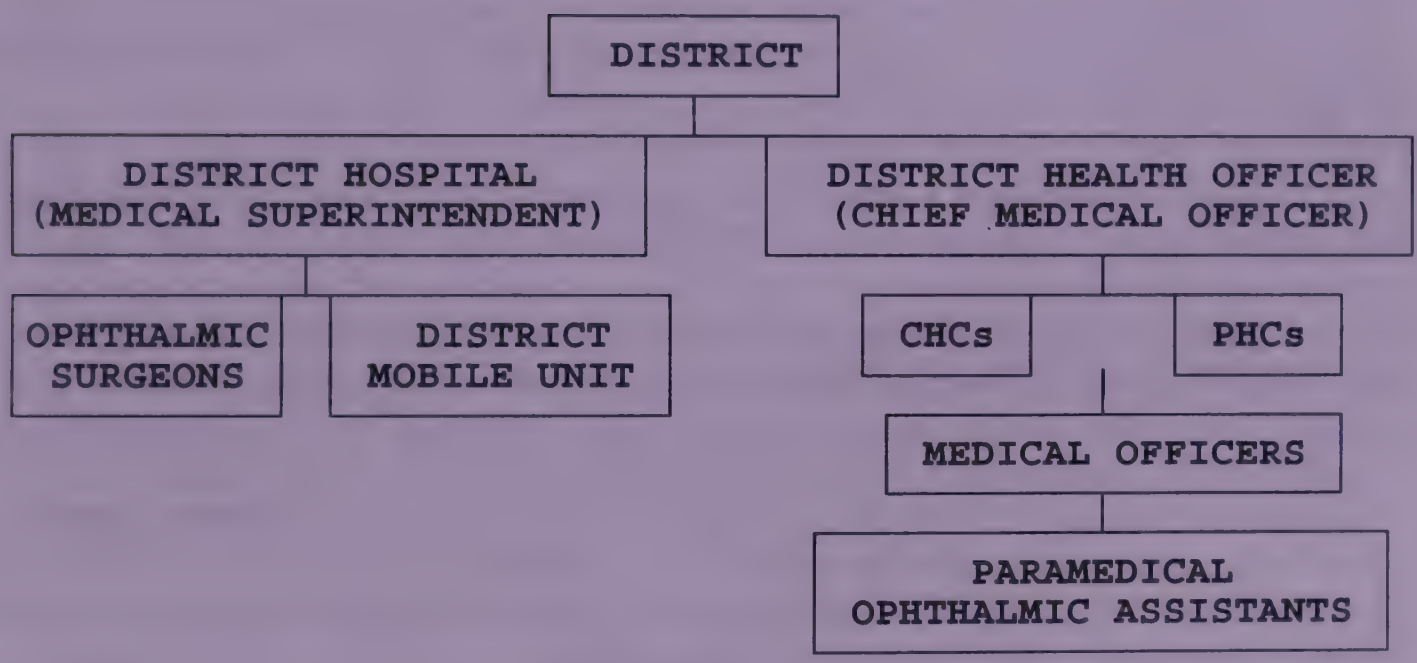
Health manpower available in rural areas like health workers, health assistants, block extension educator etc. should be utilised for the purpose of screening of population, motivation and referral to eye camps, primary health centres and district hospitals. This would be possible with full coordination between district hospital and district health officer (Chief Medical Officer).

ORGANISATIONAL STRUCTURE FOR NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

CENTRAL PROGRAMME CELL

STATE PROGRAMME CELL

DISTRICT BLINDNESS CONTROL SOCIETY



ROLE & RESPONSIBILITIES OF DISTRICT PROGRAMME MANAGER (DPM)

K.P.N.GOWDA

LEARNING OBJECTIVE:

At the end of the session, the District Programme Manager should have clarity about his role in the programme and for the efficient functioning of District Blindness Control Society.

District Blindness Control Societies were first established and tried out in 5 Pilot Districts in the Country in Basti (Uttar Pradesh), Bhandara (Maharashtra), Purnea (Bihar), Salem (Tamilnadu) and Tumkur (Karnataka) during 1990. The Success story of the pilot Districts was instrumental for the acceptance by the Government to introduce the concept of DBCS throughout the country, in each district, as district is the accepted unit for the implementation of all development programmes.

DBCS is established through a Government order and is an autonomous Registered Society Registered under " The Societies Registration Act, 1860.

District Collector/District Magistrate/Deputy Commissioner is the Chairman and Chief Executive officer of Zilla parishad is the Vice Chairman of the DBCS. DBCS has official and nonofficial members, the maximum strength being 20. To coordinate the working of DBCS and all NPCB activities in the District, District Programme Manager (DPM) is appointed by the Chairman. DPM is also the Member Secretary of the DBCS. DPM is a catalyst and not an executive. He is not a Government Official. He acts as a link between DBCS, District Authorities and the State Government. He is more like a liaison officer.

COORDINATION

DPM has to establish good rapport with the District Collector/ Deputy Commissioner (DC)/ Medical Superintendent (MS), District Health Officer (DHO), Deputy Director of Public Instruction (DDPI), Ophthalmic Surgeon(OS) in Govt.service, Private Ophthalmic Surgeon, Ophthalmic surgeon of Medical colleges etc, Voluntary organisations, Auxillary Nurse Midwives Training Centre (ANMTC), District Health Education Officer (DHEO), Assistant District Health Officers (ADHOs), Medical Officers of Primary Health Centres (PHCs), DBCS members, Para Medical Ophthalmic Assistants (PMOAs), etc. In short he has to move closely with everyone who is directly or indirectly connected with NPCB work. He has to discuss in detail Various plans and strategies and convince them and obtain their full and whole hearted cooperation.

DPM has to mix with every health worker, move with them, adjust with them and work with them. He should never neglect or ignore any health functionary however junior he may be and make them feel a member of the team. Ego must be kept at the lowest level because at times personal ego is the real stumbling block. Remember "Where every thing fails, patience succeeds".

SITUATIONAL ANALYSIS

DPM should visit each and every upgraded Primary Health Centre (PHC), CHCs, DMU, District Hospital to complete the situational analysis regarding, manpower, Instruments, equipments, drugs, etc. By this he will assess the availability, needs, replacements required etc.

DPM will have to meet the Chairman and other key officials of the DBCS very frequently for some discussions, clarifications, planning etc. etc,.

PLAN OF ACTION

Depending on the situational analysis and the needs of the District, Annual Plan of Action (POA) has to be prepared. DPM has to prepare POA which should have components like (a) Cataract Surgery (b) School Eye Screening programme (c) Health Education activities (d) Rehabilitation of the blind and any other activity specially required for his district. POA must be prepared depending on the funds available, and other resources and infrastructure available. POA should be practicable and not overambitious. The POA has to be discussed threadbare at the DBCS meeting and adopted.

DBCS MEETINGS

DPM is responsible for conducting at least four DBCS meetings in a year. All activities of the DBCS must be approved either before or post facto at the DBCS meetings. Adequate notice must be given to all members so that majority of them attend it. DPM should prepare the agenda carefully and send the agenda in advance so that members can study and actively take part in the deliberations of the meeting. Pre-meeting lobbying on important agenda items will be quite useful to get the support by everyone. A prior briefing of the Chairman before the meeting, on the agenda items will help in arriving at quick decisions. Approval of DBCS should be taken for any activity already undertaken and activities proposed to be undertaken.

Maintain DBCS accounts properly as per approved norms and get them approved by the DBCS.

SUBCOMMITTEE

For the day to day functioning of DBCS, it is advisable to form a subcommittee with M.S. as Chairman. DHO as co-chairman, DPM and the Government O.S. as member. Subcommittee meetings should be held on a fixed date and at a fixed time once a week, at a fixed place. No meeting notice will be required

for this. Proceedings should be drawn and got approved by the Chairman, which should be later on got ratified by the main DBCS. This will help in the smooth running of all the activities under NPCB by DBCS.

PURCHASE COMMITTEE

Purchase committee should include one Government O.S. and DPM. This committee will be responsible to purchase, to provide/to supplement drugs, Instruments, disposable, etc to the District Hospital, District Mobile Unit, Central Mobile Unit, Primary Health Centre, etc, for better functioning and to conduct more eye camps. Quality should be an important criteria in purchases.

MEDICAL OFFICERS MEETING

DPM has to attend without fail all the monthly M.Os meeting at the DHO office. These meetings are very crucial for fixing dates for eye camps, training of health workers etc. In these meetings the eye camps of the succeeding month are confirmed and tentative dates for eye camps for the month after the succeeding month are fixed. M.Os are requested to give the dates on which they can conduct eye camps in their area with the cooperation of local Voluntary organisations. This is a better way than our forcing on them some dates for eye camps.

PMOAs REVIEW MEETING

This should be conducted at the DHO office. DPM has to attend and review along with DHO. PMOA is the grassroot level worker under NPCB. Do not ignore him. Make him work better, not only in his PHCs, but also in satellite hospitals, in the eye camps, in School Eye Screening etc. They should be provided Registers, OPD slips, spectacle prescription slips etc.

VOLUNTARY ORGANISATIONS

DPM has to make a list of all Voluntary organisations and NGOs in the District. Contact them personally and motivate them to sponsor eye camps in different areas. Cataract surgery is the most important activity in the programme. No taluka in the district should be neglected for conducting eye camps.

DISTRICT LEVEL ORIENTATION CAMP (DLOC)

DPM has to arrange a DLOC involving all government departments, NGOs, Voluntary organisations, philanthropists, press etc, in order to sensitize them about NPCB & DBCS and to enlist their cooperation. Issue appreciation certificates to good workers.

INSERVICE TRAINING

DPM has to organise inservice training to PMOAs, Health Assistants (HAs) etc. Provide HAs with catcards and referral slips. This will help in better attendance

at eye camps, better skills in eye health care delivery and improvement in quality of services. PMOAs and HAs can be used in eye OT and post operative eye care. PMOAs can also be used very actively in School Eye Screening programme.

SCHOOL EYE SCREENING PROGRAMME(SES)

DPM has to arrange(with full cooperation of DDPI and Assistant Education Officer(AEOs),teachers training and SES programme for Higher primary school students.

HEALTH EDUCATION (HE)

DPM has to arrange for HE activities to enlighten the public about NPCB, DBCS, eye health care and facilities available - by producing supplying posters, cinema slides, pamphlets, leaflets, appeals, audio/video cassettes, etc.

COMMUNITY BASED REHABILITATION (CBR)

DPM has to arrange CBR for the incurably blind persons by using National Association for the Blind (NAB). DPM has to supervise, coordinate and be a part of these activities at the district level.

SURVEYS

DPM can organise small scale surveys if required and initiate any other innovative activities in the district with the approval of the DBCS.

OFFICE

DPM has to maintain his office well, with a tidy look and keep all records and registers updated including statistical data. He should collect the catops figures in the whole district to the best possible extent, analyse them - Talukawise, unitwise, monthwise and by unit of service delivery (Dist.Mobile Unit (DMU), Central Mobile Unit (CMU), NGOs etc). An analysis of the percentage of achievement of the target will help to decide the future course of action.

Office accounts must be properly maintained by the DPM. DPM should gaurd the assets of the DBCS and the office well.

DPM should send returns both regarding activities and accounts properly and regularly with the help of office assistant. He should maintain the office vehicle in good condition. DPM should maintain updated list of names, addresses, and telephone numbers of all important officials and non officials in his district. DPM should develop leadership qualities. He has to know more than others but should not show any superiority feeling. DPMs knowledge should make others to request him for advice. DPM should be humble and always tell others that he is there to assist them and he always guard the interests of DBCS and NPCB.

MANAGING RESOURCES

G.V.S.MURTHY

LEARNING OBJECTIVES

At the end of the section and exercises, the District Programme Manager (DPM) should be able to:

1. Understand the mode of managing equipment
2. Understand the system of materials management
3. Manage receipt and issue procedures
4. Manage Stores
5. Plan Supervisory Functions
6. Manage Time
7. Manage the Office
8. Manage the Transport requirements

At present, the utilisation of all resources available for eye care services is around 40%. The main reason for this low utilisation is the poor management of these resources. Staff may be appointed for a mobile unit, but the vehicle and the equipment may be lacking. Another unit may have staff, vehicle and equipment, but there may be no provision to buy sutures or drugs. A third unit may have all resources to conduct up to 100 surgeries in a camp, but finds only 5 patients because the publicity was not done.

Acknowledging the need for better management of eye care services at the district level, the Government of India has appointed District Programme Managers (DPM) to take care of the managerial function of the DBCS.

To perform various activities required for the success of the programme, it is important that all the available resources are judiciously utilized to produce the best results. Resources refer to manpower, time, equipment, material, drugs, finances etc. available in the district. The efficient use of such resources is the prime responsibility of the programme manager.

There is no organization which always has surplus resources. Constraints are very common. The hallmark of a successful manager is to make optimal use of the available resources.

Time and again people are faced with problems which should never have surfaced if the resources were properly managed.

EXAMPLES:

(a) The operating team is leaving for a camp and during operations ophthalmologist finds that there is not enough suture material.

(b) In the middle of a training programme to train teachers in school eye screening it is found that the manuals are not printed correctly.

(c) Half way during the peak cataract session, the DPM finds he has no money for petrol.

Managing resources include procedures like procurement, storing, preventive maintenance, manpower development, office management and accounting. Some of these aspects are covered in the other sections and will not be considered here.

PROCURING RESOURCES

Procurement of drugs and equipment is an important function of the DPM. Unless material of proper quality is available in the required quantities, the programme may ground to a halt. DPM should anticipate these problems and take corrective action.

The rules governing procurement by the DBCS are detailed in a different chapter. It should only be remembered that set procedures should always be used to procure resources.

MANAGING EQUIPMENT

Material equipment is generally classified into 2 broad categories:

1. Consumable (expendable) equipment. This includes all equipments which are used up within a short time, cotton, stationary, drugs, suture material, spectacles, cataract knives, etc. Such materials have to be replenished regularly.

2. Non-consumable (non-expendable) equipment. This includes equipment which lasts for many years and thus requires proper care and maintenance. Ophthalmoscopes, Trial Lens Sets, furniture etc. are examples of non-consumable items. These items are not replaced or replenished on a regular basis. Most of the equipments are given in kind by Government of India.

When procuring equipment, the following points/should be considered:

- Life span of the material. This varies for different items :-

Sharp Instruments	50-100 operations
Furniture, Vehicle	8 years

- Availability in the local or other markets.

- Lead Time: this refers to the time duration between the ordering and actual receipt of the equipment. Very long lead times can upset the programme. If lead time is not accounted for, the DPM may have to face periods of material shortages that will affect the output badly. For example, if you order for new cataract sets, it may take one or two months before you actually receive them. You have to order them well in time to ensure that they are with you when

they are needed.

- All vital equipment should be checked at frequent intervals to see their functioning.

MANAGING DRUGS

The DPM may have to procure and issue drugs and sutures as and when required to the eye care units in the district. In managing drug supplies, the following points should be kept in mind:

- Wastage of drugs at the periphery is common. Supervision and cross checks can reduce wastage to a large extent.

- Procuring drugs and sutures in excessive quantities, much more than what is actually needed, can lead to storage and issue problems. The risk of exceeding the expiry date and thereby wastage is high.

- Vital or life saving drugs like Hydrocortisone or Adrenaline injections and essential drugs like Xylocaine should be regularly monitored.

- Shelf life of drugs should be known. All companies prominently display the same. In your store you will have to ensure that old stocks have to be finished first before using the latest supplies for an eye camp.

- A standard list of requirements for an eye camp should be prepared. This will vary for each district. If Trachoma is endemic, Tetracycline eye ointment should be available at all PHCs.

RECEIPT AND ISSUE PROCEDURES

When any new material (drugs or equipment) is received by the DBCS, it is accompanied either by an INVOICE (if the payment has not yet been made) or a DELIVERY NOTE (if the payment has already been made). This should be filed separately.

The receipt of material should be immediately entered in the stock ledger. Separate ledgers should be maintained for consumables, non-consumables and drugs. An alphabetical index should be maintained on the first page and each item should be recorded on a separate page, with the following information:

DATE OF RECEIPT	ITEM	INVOICE/ DELIVERY NOTE NO.	RECEIVED FROM	QTY. RECEIVED	QTY. ISSUED	BALANCE IN STOCK

The ledger should be updated immediately when any stocks are received or issued.

Materials procured by the DBCS will be issued to various Units. The issue should be recorded in the stock ledger and an ISSUE SLIP should be prepared in duplicate. One copy should be handed over to the receiving unit while the other copy duly signed by the receiver should be filed. Such a slip should contain the following information:

1. Date of issue
2. Specifications of items issued
3. Quantity issued
4. Page No. in stock ledger
5. Name & signature of person receiving material
6. Name & signature of person issuing material

It is important to remember that well cared for equipment lasts longer and material used correctly is not wasted. The DPM should motivate all district staff to regularly clean, inspect and maintain equipment. Any repairs if due should be promptly undertaken as also the replacement of obsolete items. Equipment and material should be returned clean and in good order to its correct place after use. This ensures a longer life of all equipment. Periodic physical verification of stocks i.e. (once in 3 or 6 months) is very important.

The balance in the stock ledger serves a timely warning and guards against items being 'Out of Stock'.

MANAGING STORES

An *inventory* is simply the list of items that are kept at a certain place, irrespective of whether they are idle or in use. Each unit in the eye care infrastructure should maintain an inventory. Inventories ONLY pertain to the non-consumable items. New equipment received should be added to the Inventory. The inventory is used to check the stocks of equipment in use or lying idle at periodic intervals.

In storing drugs and equipment the following should be kept in mind:

- Store materials in a cool dry place away from sunlight
- Proper stocking reduces wastage of storage space.
- Store rooms should be rat and termite proof
- Dampness or seepage should be avoided.
- Material received earlier should be issued first. One way of doing this is by keeping old stocks in front and new stock at the rear of the shelf

- Drugs nearing their expiry date should be kept in specially labelled boxes. A red star can be attached on the boxes to permit easy identification.

SUPERVISORY FUNCTIONS

Supervision implies not only monitoring of the work output but also instructing and influencing the subordinate workers. Supervision is meant for constructive and supportive action and NOT for policing and victimization.

It is important for the DPM to pay attention to a worker's problems, while at the same time ensuring that the work output does not suffer. During supervision, pay adequate attention to the following:

- look at maintenance of records
- observe all aspects of a workers functioning
- at the end, appreciate the good points, point out any discrepancies and advice the workers on how output can improve.

MANAGING TIME

Time is an important resource which is most often neglected. The management of time has two major areas:

- An investigation of how the staff engaged in eye care programmes is utilizing the available time.
- Planning time tables, schedules and programme charts.

The section on Planning of district level programmes has dealt with most aspects of time management. In addition, you must keep the following in mind:

- Your own activities need to be timed. You may like to know how much time is spent with correspondence, in talking to staff at various levels, in visiting the district and in liaising with the district authorities. You can delegate time to each activity so that adequate attention is paid to all components. Maintaining a daily time dairy can help you in effective use of time.
- In preparing schedules for camps and mobile units, it is useful to prepare a map showing routes, distance and travel time. The travel time will depend on the road conditions in addition to the distance.
- In planning a camp programme, allowance should be made for festivals and fairs in the area, elections, etc. Ensure that these periods are avoided.
- Always prepare a year's calendar. The same should be displayed prominently in your office. The calendar helps in 2 ways:

1. It reminds you of the definite events planned for the year.

2. It shows where you can fit in some unexpected events like special meetings or visits by dignitaries.

Always enter dates you wish to be reminded of and all public holidays.

MANAGING YOUR OFFICE

A good manager pays adequate attention to the space where staff work. Irrespective of the size of the room, alterations are possible and this will smoothen your functioning. Always consider two things for allocating office space:

1. What work will be done in the office ?

2. Can space be arranged in a better fashion to suit your needs ?

A common space problem relates to storage space. Using steel racks, almirahs or filing cabinets is essential. If the room is small storage racks can line the corridor. Placing racks against the wall allows more moving space.

Most of the office equipment which a DPM needs is basic. The following should be available:

- 2 steel almirahs for important documents, drugs and instruments
- 2 closed steel racks with locking systems for the remaining drugs and instruments
- An office table
- 3-4 chairs
- A filing Cabinet
- A type writer
- A water jug and a few glasses

The annual camp schedule, a year planner and a map of the catchment area detailing proposed camp sites should be displayed in the room. Educational material should also be displayed.

Local maps will be available from the district and revenue authorities. These maps may have some unwanted details. In that case, the outlines of the map can be copied on a transparent paper and the requisite points may be entered. If no official map is available, a rough sketch map may be used.

The DPM should ensure that he is available in the office for a fixed period every day. This allows all others to contact him when required. For example - the DPM may announce that he will be available in the office every afternoon between 3-5 p.m. A notice to this effect can be posted on the door.

The office is mainly meant for paper work and for liaison. The following paper work is required for the DPM:

1. Correspondence letters to and from supervisors, subordinates and medical officers.
2. Camp schedules, time table, annual plans etc.
3. Monthly report form
4. IEC material
5. Staff files
6. Stock ledgers
7. Issue vouchers
8. Invoices and delivery notes
9. Account books
10. File recording minutes of the meeting of the DBCS
11. Training materials/schedules etc.

For orderly management, a filing system should be set up. A filing system is an arrangement by which different types of papers are placed in separate files. This enables them to be found again rapidly. A good filing system should include all materials, be simple and quickly retrievable. The files can be stored subject wise in an alphabetical order.

Example

(a) Camp Schedules
(b) Delivery notes
(c) Issue Vouchers
(d) General Correspondence
(e) Monthly Reports etc.
(f) Official correspondence (CMO, SPO)

An INDEX of the files should always be maintained to allow easy access to files. An index should be prepared alphabetically.

Space should be created to maintain the office accessories also. One rack in a shelf can be used for this purpose. Office accessories include stationery, envelopes, official forms, gum, scissors, cellotape, wrapping paper, string, tags, pens, pencils etc.

TELEPHONE

An important instrument for communication is telephone. One telephone should be made available to the DPM. The telephone is essential for effectively running the district programme, but equally important is to prevent misuse of the instrument. Since the DPM will not always be available in the office, care should be taken that others do not take advantage of the situation. Some guidelines for telephone use should be kept in mind:

- always keep the telephone locked
- ensure that a log book is maintained and every call made is entered in the log book and countersigned by you.
- ensure that no STD facility is available on the telephone. Any STD calls required can be made from a PCO and the bill can be reimbursed from the DBCS.
- ensure that telephone bills are paid promptly to avoid disconnection.

MANAGING TRANSPORT

Many a time, the money spent on transport is often out of proportion to the other expenses. The life of a vehicle ranges from 50,000 Kms to 160,000 Kms or even more depending on the driver, maintenance and road conditions.

Preventive maintenance is nowhere more important than in managing vehicles. Regular servicing at the prescribed mileage limits will save money and unnecessary hardships in the long run. It is convenient to undertake a number of servicing and maintenance procedures at one go rather than getting one thing done at a time. A maintenance chart should be maintained in the office of the DPM so that a cross check can be conducted rapidly.

The vehicle should always be fitted with a maintenance kit or tool box containing screw drivers, spanners, jack-handle, and a reliable spare wheel.

An important factor determining the life span of a vehicle is the attitude and skills of the driver. A careful driver and one employed on a contract rather than regular salary is usually a better option.

A log book and a repair and maintenance book should be meticulously maintained and scrutinized at regular intervals. Keeping an eye on the milometer when travelling will allow a proper scrutiny of what the driver is entering in the log book. All entries in the log book should be completed and counter signed immediately. Indicate clearly the purpose of a journey and starting point and destination. 'Official duties' or 'local duties' does not convey anything.

Though exact expenditure on a vehicle cannot be anticipated in advance, you should endeavour to allocate a reasonable proportion of your budget for transportation. A new vehicle should give you 10-12 Km for every litre of petrol. The vehicle should only be used for the official duties. Approximately 15% of the fuel costs will be required for maintenance expenditure. If the vehicle is used properly the expenditure on fuel will never exceed 20% of the total expenditure of the DBCS.

If the vehicle is not available due to a breakdown, you should not stop the activities planned. A hired vehicle can always be arranged. Taxi operators generally have fixed tariffs for each location. Ensure that receipts are available for all such journeys. Such vehicles can also be used for transporting camp personnel from the district headquarters.

Districts without a vehicle for the DMU can also operate with a hired vehicle. It has been calculated that, on a year basis, if less than 100 camp trips are made, it is cheaper to hire a vehicle than to own one yourself.

Attention to all the above facts of management will make the DBCS an effective and viable option for control of blindness in your district.

Exercises

1.

ITEM	STOCK	UNIT/ PATIENT	(1)	(2)	(3)
sutures	5 boxes of 12	1/5			
xylocaine	10 vials	1/10			
eye pads	84	1/1			
diamox	70 tabs	2/1			
gentamycine eye drops	300 bottles	1/10			
cataract knife	5	1/30			

QUESTION 1:

Write in column (1) the number of cataract patients for which the present stock would be adequate.

QUESTION 2:

Knowing that you have an eye camp every week, and you are expecting 40 patients in the first week, 35 in the second, 120 patients in the third week, indicate

which items you would order first by ranking them in column (2). Explain your choices in column (3).

2. An eye camp is organized in your district next week. The admission day is Saturday, the operation day is Sunday. You are expecting 500 patients in the OPD and 60 cataract cases to be operated.

1. Indicate what you consider the minimal requirements on:

	NUMBER
PMOAs	
GDMOs	
OT Staff	
Operation Tables	
Cataract set	
Sutures	

On Saturday you find that many more patients have come to the camp. Over 800 patients were seen and 110 were selected for cataract surgery. The accommodation at the camp site is for 70 patients only.

2. What will you do? Describe at least three different solutions to this problem and indicate what you consider the best.

Option - (1)

Option - (2)

Option - (3)

FINANCIAL MANAGEMENT BY DISTRICT BLINDNESS CONTROL SOCIETY

RASHMI DHAMIJA

LEARNING OBJECTIVES :

1. Understand the basic concepts of Accounting and become familiar with the various terminologies used therein

2. Appreciate the autonomy of the DBCS in financial/accounting matters and describe the difference between the DBCS and the Govt. procedures.

3. Prepare the budget as part of the Annual Plan of Action of the district

4. Use correctly all the Forms & Registers and follow standard procedures for all transactions and for maintaining the records of the DBCS

5. Compile the Final Accounts, i.e., Balance Sheet, Income & Expenditure Account, Receipts & Payments Account and the Schedule of Fixed Assets, in the prescribed proforma

6. Realise the importance of getting the Accounts audited by a Chartered Accountant and diseminate the statements as per prescribed procedures.

METHODOLOGY :

Financial Management skills allow the District Programme Managers to increase the value they get for their money or resources.

The Session will begin with an overview of the salient features of the financial/accounting system with emphasis on how it differs from the established Govt. procedures. The basic concepts of accounting and also the Forms & Registers to be maintained by the DBCS will be described in detail. This will be followed by Group Exercises on Budgets and Accounting procedures & concepts.

RESOURCE PERSON :

A qualified Accountant with experience of handling Govt. Accounts.

RATIONALE FOR ESTABLISHING DBCS

Administrative & financial procedures in the government system are extremely tedious. It takes a long time to obtain approval
for a decision / sanction thereby halting an activity and resulting in costly resources remaining idle for long periods of time. It also leads to demoralisation and frustration of the functionaries involved in service delivery.

Through the DBCS, it is expected that quick and timely decisions will be taken to streamline the services and optimise the output, thereby making the Programme more effective.

SOCIETY'S FUNCTIONING VIS A VIS GOVERNMENT FUNCTIONING

1. The Govt. has an established accounting / financial management system whereas the DBCS (by virtue of being a Society) is expected to develop its own procedures.

2. The Society has the powers to raise funds / resources other than Govt. grants.

3. The DBCS is not a Government department or agency but works as an autonomous Society within the overall framework of the NPCB.

NEED FOR FINANCIAL MANAGEMENT

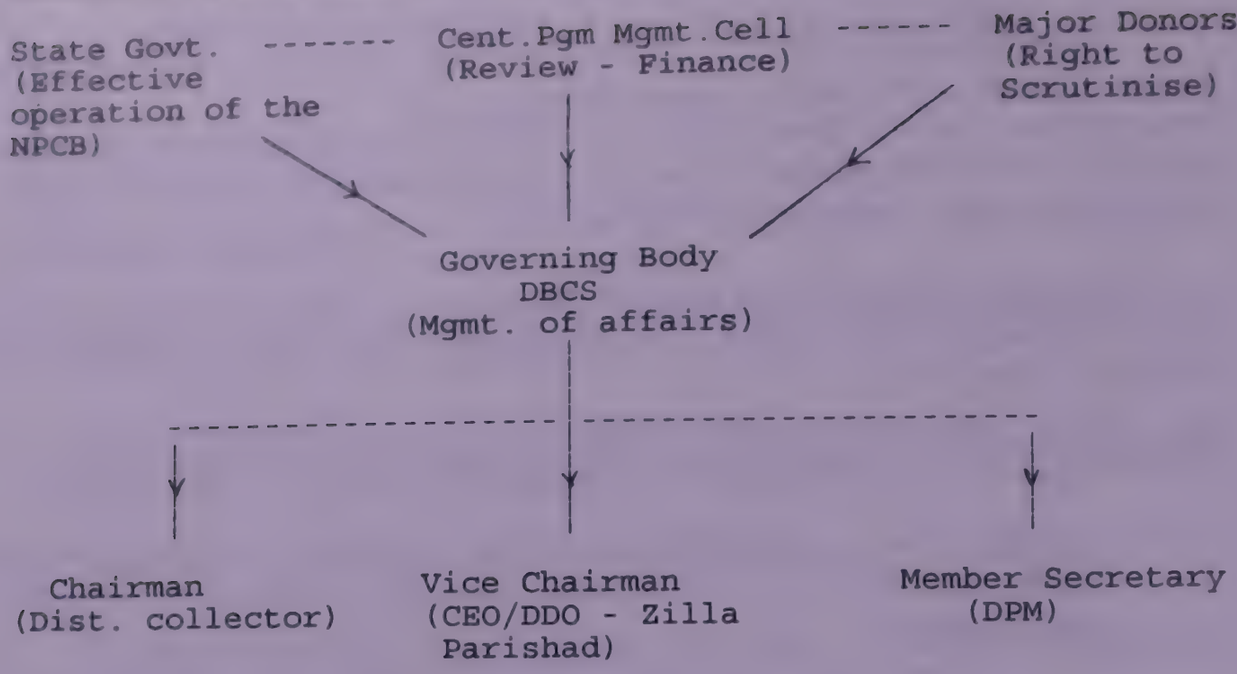
Finance is to an organisation what blood is to the human body. Proper financial management consists of a dynamic approach towards the achievement of an organisation's objectives.

1. It augments the productivity of the Programme by optimising the use of manpower & infrastructure.

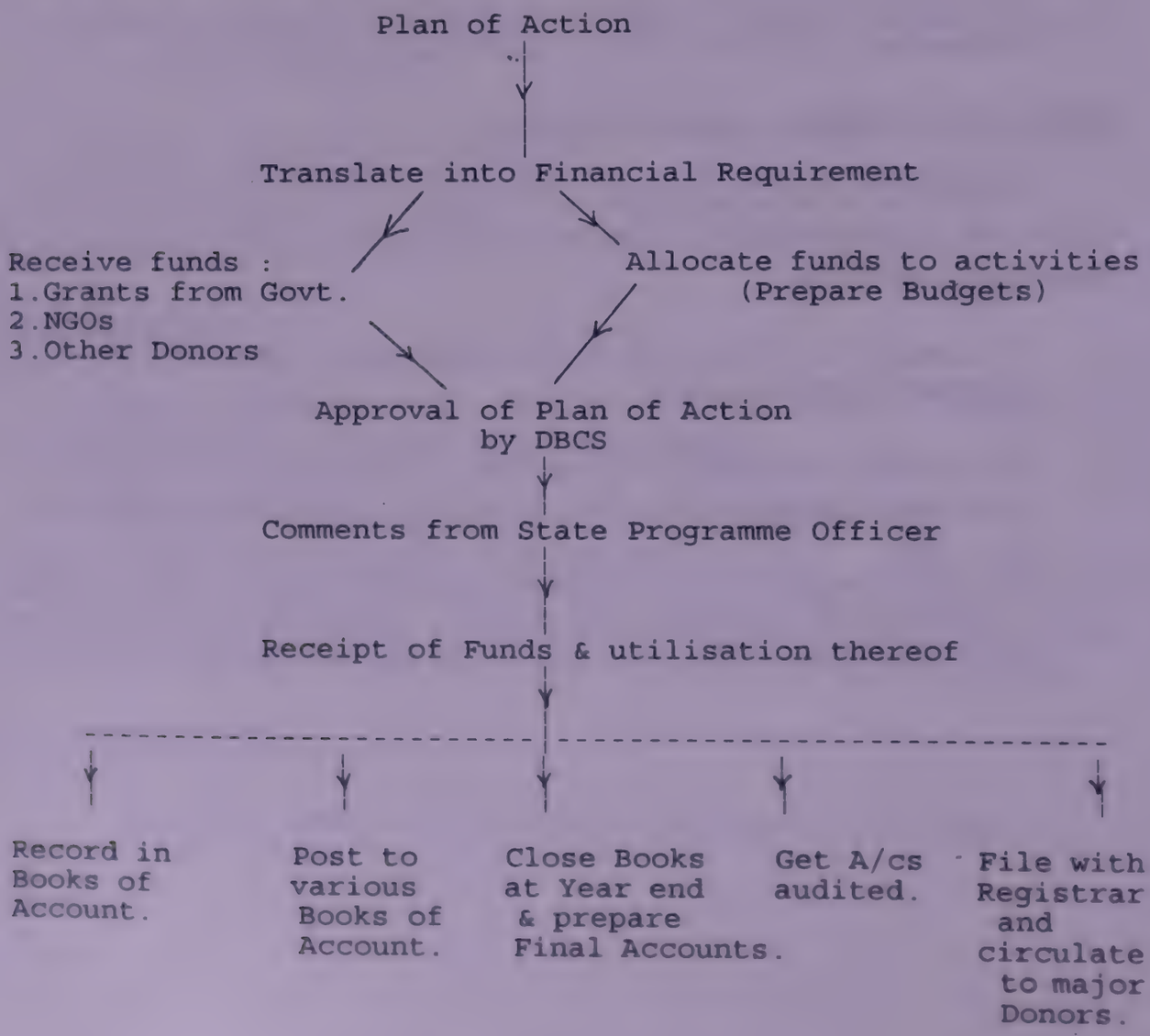
2. By providing information on all activities, in financial terms, it helps in the decision making process i.e. what to do, how to do, how much to do, etc.

3. It is a pre - requisite for monitoring & evaluation. By comparing the budgets / estimates with the actuals and assigning reasons for variances, various aspects / activities of the programme can be evaluated and improved upon.

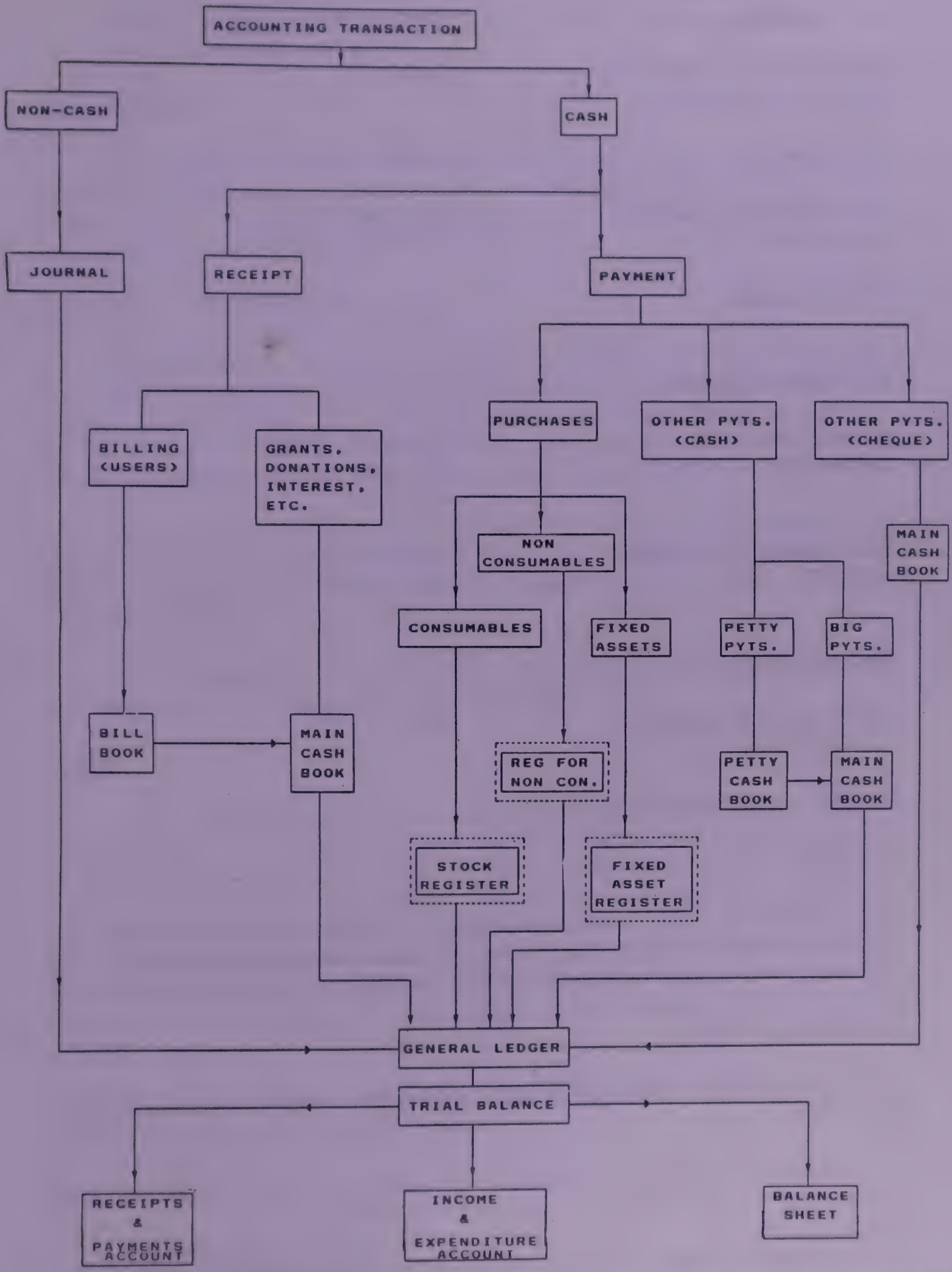
ORGANISATION CHART :


State Govt. (Effective operation of the NPCB)
Cent.Pgm Mgmt.Cell (Review - Finance)
Major Donors (Right to Scrutinise)
Governing Body DBCS (Mgmt. of affairs)
Chairman (Dist. collector)
Vice Chairman (CEO/DDO - Zilla Parishad)
Member Secretary (DPM)

FLOW OF ACTIVITIES (FINANCE RELATED) :


Plan of Action
Translate into Financial Requirement
Receive funds :
1.Grants from Govt.
2.NGOs
3.Other Donors
Allocate funds to activities (Prepare Budgets)
Approval of Plan of Action by DBCS
Comments from State Programme Officer
Receipt of Funds & utilisation thereof
Record in Books of Account.
Post to various Books of Account.
Close Books at Year end & prepare Final Accounts.
Get A/cs audited.
File with Registrar and circulate to major Donors.

FLOW OF ACTIVITIES THROUGH THE ACCOUNTING SYSTEM



NOTE: Records boxed-in with a double line are memorandum records only & do not form part of the double entry system

JOB RESPONSIBILITIES (FINANCE RELATED) :

Activity	Responsibility
Plan of Action : Translation into financial requirement	DPM
Plan resources	DPM
Submit Proposal & obtain commitment	Chairman / Vice-Chairman / DPM
Prepare Budgets	DPM under guidance of Ch.man/V.Ch.man
Get Budgets approved	Chairman
Authorise receipt & disbursement	Chairman / DPM / DOS (any two signatories)
Book keeping & Accounts preparation	General Assistant under supervision of DPM
Get Audit done	---"---
File Accounts & circulate to major Donors.	DPM

MAINTENANCE OF ACCOUNTS

Accounting

Accounting is the language of business. The affairs of an organisation are communicated to others as well as to those who own or manage it through accounting information which has to be suitably recorded, classified, summarised and presented.

Double Entry System

This system recognises the fundamental fact that every transaction is a double sided affair.

Accounts can broadly be categorised into three types. The rules as regards the double entry in case of each of these types are as under :

1. Personal Accounts (relating to persons) : Debit the receiver & credit the giver.

2. Real Accounts (eg. cash, furniture, etc.) : Debit what comes in and credit what goes out.

3. Nominal Accounts (eg.salary, rent, etc.) : Debit all expenses (and losses) and credit all incomes (and gains).

Accrual Concept

Transactions should be recorded in such a manner as to reflect the true position of the organisation. Even though it is assumed that business will continue for a long time, it is necessary to keep accounts so as to permit results being ascertained and presented for each financial period, usually a year.

Cash Book

The Cash Book is meant to record all cash transactions, whatever their nature. It is divided into two sides - the left hand side for receipts of cash and the right hand side for payments. Since in modern times, transactions with or through the bank are even more numerous than the cash transactions, each side has two columns - one to record cash transactions & the other for bank transactions. (Format - I of Guidelines)

Sometimes cash is deposited in the bank and sometimes it is withdrawn for use. In this case, entries both for receipt & payment will appear in the cash book itself in appropriate columns. Such transactions are called CONTRA TRANSACTIONS.

It is customary to put the word "To" before all entries on the debit (left) side and "By" before all entries on the credit (right) side.

Ledger

After recording transactions in the various Subsidiary Books (or Books of Original Entry) it is necessary to process the entries further and recast them so that all transactions of a kind for the whole period are brought together. The Book which contains accounts is known as the ledger. Since the final information pertaining to the financial position of an organisation emerges only from accounts, the Ledger is also called the Principal Book. The Cash Book has a unique position. It is a Subsidiary Book because cash/bank entries are first entered here and then other accounts are prepared. But it also contains the two accounts of Cash & Bank itself and hence it is a part and parcel of the Ledger also.

In a ledger account, a reference is made to the original entry by entering the relevant page number in the folio column.

Trial Balance

According to the principle of double entry system, every amount that is placed on the debit side of an account must have a corresponding entry on the credit side of some other account. This being the case, it is but natural that the total of all the debit

balances should agree with the total of all credit balances. A Statement which tabulates the debit & credit balances is known as the Trial Balance.

Bank Reconciliation Statement

It is customary for a bank to send to its customer regularly a statement showing how his account stands. Usually, there is a little book through which the bank informs the customer as to what balance he has at the bank. This is the Bank Pass Book. It stands to reason that the balance shown by the Bank pass Book should agree with the bank balance shown by the Cash Book. However, often there is a difference even if there is no mistake. The difference is due to the following reasons:

1. Cheques received are entered in the Cash Book as soon as they are received. There may be a delay of a day or two in sending the cheques to the bank. Besides, the bank does not credit the customer until the cheques are realised; if they are on other banks, it means delay. In the meantime, therefore, the Cash Book will show more balance than what the bank shows in its own books (Cheques deposited but not credited).

2. As soon as cheques are issued they are entered in the Cash book, but the bank makes no entry until they are actually presented for payment and are paid. This means that the bank shows a higher balance in favour of the client than what the cash book of the client shows.

3. The bank often makes charges for services it renders; these are known as bank charges. These are entered in the Pass Book and the entry is generally made in the cash book only when the pass book is received.

These delays do not matter as sooner or later both the bank & the client will make entries. However, to be sure that no mistakes have been committed, there must be a statement to explain why there is a difference between the two balances on a particular date. This statement is known as the Bank Reconciliation Statement. It is generally prepared at the end of each month. (Format - VII)

Capital / Revenue Expenditure

If the benefits of an expenditure are expected to accrue for a long period of time, the expenditure is capital exp., eg. land, buildings, machinery, etc. All these things stay with the organisation and can be used over and over again.

An item of expenditure whose benefit expires within the year or exp. which merely seeks to maintain the activities or keep assets in good working condition is revenue expenditure., eg. salaries & wages, fuel , electricity, etc.

RECEIPTS & PAYMENTS ACCOUNT

Following are the features of the Receipts & Payments Account :

1. It commences with the opening balance - cash & bank. This is put on the debit side.

2. Only actual cash transactions will be shown in the Account. Receipts of cash (or cheques) are put on the debit side & payments on the credit side.

3. All cash transactions will be reflected in the Account - whether capital or revenue, whether pertaining to the previous year, present year or next year.

4. The difference between the two sides represents cash in hand & balance at bank, if the debit side exceeds credit. If the credit side exceeds the debit, it represents the net bank overdraft. (Format - IV)

Income & Expenditure Account

The Income & Expenditure Account is an Account which summarises the expenses & receipts for the period (year) under consideration. Any outstanding expenses should be added and the expenses paid in advance should be deducted. Care should be taken to exclude the items of capital nature. The excess of income over expenditure and vice versa is transferred to the Balance Sheet. (Format - V)

Balance Sheet

The Balance Sheet is defined as a statement summarising the financial position of an organisation on a given date. It summarises, on the right hand side, the assets and on the left, the liabilities of the organisation. A Balance Sheet is prepared as on a certain date and not for a period (unlike a Receipts & Payments A/c or an Income & Exp. A/c). (Format - VI)

Audit

Audit can be classified into two categories - Internal & External or Statutory. Internal audit may be conducted by an internal department / cell or it may be entrusted to an outside agency. It is got done by the organisation to ensure accuracy of accounting, to point out areas of weaknesses in the system, etc. External audit is a statutory requirement and is conducted in accordance with the governing statute. Thus the audit of Societies is done under The Societies Registration Act, 1860. It is conducted by a firm of Chartered Accountants appointed by the members in the Annual General Meeting. The end result is a Report on the accounts for the year audited & is drafted in the prescribed format. If the auditors do not have any reservation on the accounts, it is called a clean report, otherwise it is called a qualified report, in which case the auditors bring out their reservations in their Report. The effort should be to clear all queries of the Auditors during the Audit process so as to avoid qualifications in the Report.

NAME OF THE DBCS _____

FIXED ASSETS REGISTER

PURCHASE						SALE		
DATE	VR.NO	DESCRIPTION	ASSET S.NO.	AMOUNT	LOCATION	DATE & VR.NO.	SALE VALUE	PROFIT/ LOSS

FORMAT VII

NAME OF DBCS _____

BANK RECONCILIATION STATEMENT

Reconciliation of Account No. _____ as at _____

Balance as per Bank Statement		-
Less: Cheques issued but not presented		
Ch.no. Date Amount		
- - -		
- - -	-	-
Add: Cheques deposited but not credited		
Ch.no. Date Amount		
- - -		
- - -	-	-
Others		
Add: Bank charges not accounted for in cash book		-
BaLance as per Cash Book		-

EXAMPLES

QUARTERLY REPORTING FORMAT

I.

INCOME

1. Grants from GOI :	15.04.94	:	Rs. 3,00,000 /-
	15.10.94	:	Rs. 3,00,000 /-
2. Bank Interest :	30.09.94	:	Rs. 25,000 /-
	31.03.94	:	" 12,000 /-

EXPENDITURE

1. Remuneration	:	Rs. 19,500 /-	for each quarter
2. Sutures & Drugs	:	" 50,000 /-	Qtr. I
		" 75,000 /-	Qtr. II
		" 40,000 /-	Qtr. III
		" 25,000 /-	Qtr. IV
3. POL & Maintt.	:	Rs. 8,000 /-	for each quarter
4. Spectacles	:	Rs. 2,000 /-	Qtr. I
		" 2,000 /-	Qtr. II
		" 1,500 /-	Qtr. III
		" 3,000 /-	Qtr.IV
5. IEC Activities	:	Rs. 7,000 /-	Qtr. I
		" 10,000 /-	Qtr. II
6. Reimb. to NGOs	:	Rs. 3,000 /-	Qtr.I
		" 3,000 /-	Qtr. II
		" 5,000 /-	Qtr. III
		" 8,000 /-	Qtr. IV
7. Training	:	Rs. 2,500 /-	Qtr. II
		" 1,500 /-	Qtr. III
		" 3,000 /-	Qtr. IV
8. Contingencies	:	Rs. 1,500 /-	Qtr. I
		" 2,000 /-	Qtr. II
		" 1,800 /-	Qtr. III
		" 2,000 /-	Qtr. IV

	Qtr I	Qtr II	Qtr III	Qtr IV	TOTAL
I. OPENING BALANCE	NIL	2,09,000	1,12,000	3,34,700	
II. INCOME					
1. Grants from GOI	3,00,000	-	3,00,000	-	6,00,000
2. Bank Interest	-	25,000	-	12,000	37,000
3. Other receipts	-	-	-	-	
TOTAL INCOME (I+II)	3,00,000	2,34,000	4,12,000	3,46,700	6,37,000
III. EXPENDITURE					
1. Remuneration	19,500	19,500	19,500	19,500	78,000
2. Sutures & Drugs	50,000	75,000	40,000	25,000	1,90,000
3. POL & mainten.	8,000	8,000	8,000	8,000	32,000
4. Spectacles	2,000	2,000	1,500	3,000	8,500
5. IEC activities	7,000	10,000	-	-	17,000
6. Reimburs. to NGO	3,000	3,000	5,000	8,000	19,000
7. Training	-	2,500	1,500	3,000	7,000
8. Contingencies	1,500	2,000	1,800	2,000	7,300
TOTAL EXPENDITURE	91,000	1,22,000	77,300	68,500	3,58,500
BALANCE (I+II-III)	2,09,000	1,12,000	3,34,700	2,78,200	2,78,200

II Conversion of Plan of Action into Budgets :

PLAN OF ACTION

1994 -95

Description / Activity	Time Frame	Cost (Rs.)
1. Reduce avoidable blindness	01 April'94 To 31 March'95	10,00,000
2. Improve working skills of health staff	---"---	1,20,000
3. Reduce preventable blindness	---"---	2,20,000
		13,40,000

DETAILED PLAN OF ACTION

Description	Time Frame	Cost(Rs.)
1. Reduce avoidable blindness :		
(a) Case detection - 500 books to be printed	1.4.94 to 31.5.94	25,000
(b) Publicity - 5000 posters to be printed	1.4.94 to 31.5.94	50,000
(c) Publicity - 2000 plastic charts on eye health education	1.5.94 to 30.6.94	50,000
(d) Drugs, Sutures & Spectacles	1.4.94 to 31.3.95	2,40,000
(e) Instruments & Equipment	1.4.94 to 31.3.95	6,00,000
(f) Cataract Surgery - Monthly M.O.meetings to fix camps	1.4.94 to 31.3.95	9,000
(g) Cat. Surgery - Vol. Agencies	1.4.93 to 31.3.95	Nil
(h) Review Meeting - PMOAs	1.9.94 to 30.9.94	13,000
(i) -----"-----	1.03.95 to 31.3.95	13,000
		10,00,000

2. Improve working skills of health staff :

(a) Prepare training programme for ANMs & LHVs	1.6.94 to 30.6.94	Nil
(b) Identify trainers	---"---	Nil
(c) One day training for ANMs	1.7.94 to 30.9.94	20,000
(d) Five days training for LHVs	1.7.94 to 30.9.94	60,000
(e) Intensive training - 3 PMOAs	1.10.94 to 31.12.94	40,000
		1,20,000

3. Reduce preventable blindness :

(a) Health education lectures in schools	1.4.94 to 31.3.95	Nil
(b) Two days training to PMOAs on SES	1.4.94 to 31.5.94	40,000
(c) Teachers' training - SES	1.7.94 to 31.7.94	70,000
(d) -----"-----	1.8.94 to 31.8.94	70,000
(e) Screening of students	1.7.94 to 31.7.94	Nil
(f) -----"-----	1.8.94 to 31.8.94	Nil
(g) Provision of spectacles	1.9.94 to 30.9.94	20,000
(h) -----"-----	1.10.94 to 31.10.94	20,000
		2,20,000

EXPENDITURE BUDGET FOR THE YEAR 1994 - 1995

PARTICULARS	QTR - I	QTR - II	QTR - III	QTR - IV	TOTAL
Sutures, Drugs & Spectacles	60,000	80,000	80,000	60,000	2,80,000
Training	40,000	2,20,000	40,000	0	3,00,000
Health Education	25,000	0	0	0	25,000
Publicity Expenses	1,00,000	0	0	0	1,00,000
Instruments & Equipment	1,50,000	1,50,000	1,50,000	1,50,000	6,00,000
Meeting Expenses	2,250	15,250	2,250	15,250	35,000
Administrative Expenses :					
Salary & Honorarium	22,500	22,500	22,500	22,500	90,000
Vehicle Maintt. & POL	30,000	30,000	30,000	30,000	1,20,000
Office Maintt.	3,000	3,000	3,000	3,000	12,000
TOTAL	4,32,750	5,20,750	3,27,750	2,80,750	15,62,000

NOTE : The above Budget is a highly simplified illustration of the budgeting process. No distinction has been observed between Revenue & Capital items as is normal accounting practice. Hence there is only one Budget instead of a separate Capital & Revenue Budget.

BUDGETED RECEIPTS FOR THE YEAR 1994 - 1995

PARTICULARS	QTR - I	QTR - II	QTR - III	QTR - IV	TOTAL
Grants from Central Govt.	8,00,000	0	8,00,000	0	16,00,000
Non Govt. Organisations	50,000	50,000	0	0	1,00,000
Donors	3,00,000	0	30,000	0	3,30,000
Others :					
Bank Interest	0	15,000	0	10,000	25,000
TOTAL	11,50,000	65,000	8,30,000	10,000	20,55,000

PROJECTED CASH FLOW FOR THE YEAR 1994 - 1995

PARTICULARS	QTR - I	QTR - II	QTR - III	QTR - IV
Opening Balance	0	7,17,250	2,61,500	7,63,750
Add : Receipts	11,50,000	65,000	8,30,000	10,000
	11,50,000	7,82,250	10,91,500	7,73,750
Less : Expenses	4,32,750	5,20,750	3,27,750	2,80,750
Balance	7,17,250	2,61,500	7,63,750	4,93,000

III Illustration - Dr. Viral Kure sets up practice

Entries			Accounting Rule followed	Entry Passed
1. Cash	50,000		Debit what comes in	Posted in Cash book
To Capital		50,000	Credit the giver (Capital represents Dr.V.K.'s A/c)	Posted in Gen.ledger
(Brings in Rs.50,000 as capital)				
2. Furniture	15,000		Debit what comes in	Posted in Gen.ledger & F.Assets register
To Cash		15,000	Credit what goes out	Posted in Cash book
(Purchases furniture worth Rs.15,000)				
3. Purchases	7,500		Debit expense	Posted in Gen.ledger & Stock ledger
To Cash		5,000	Credit what goes out	Posted in Cash book
To Medistore		2,500	Credit the giver	Posted in Gen.ledger
(Purchases consumables worth Rs.7,500)				
4. Cash	25,000		Debit what comes in	Posted in Cash book
To consultancy		25,000	Credit income	Posted in Gen.ledger
(Consultancy chg. during the month, Rs.100 x 10 patients/day x 25 days)				
5. M/s Medistores	2,500		Debit the receiver	Posted in Gen.ledger
To Cash		2,500	Credit what goes out	Posted in Cash book
(Balance payment made to M/s Medistores)				
6. Salaries	5,000		Debit expense	Posted in Gen.ledger
To Cash		5,000	Credit what goes out	Posted in Cash book
(Salaries to staff paid for the month)				

7.	Elec. & Water	500		Debit expense	Posted in Journal & then to Gen.ledger
	To Exp. payable		500	Credit the giver	---"---
(Creating provision for exp. accrued but not paid)					
8.	Stationery	250		Debit expense	Posted in Cash book
	To Cash		250	Credit what goes out	posted in Cash book
(Purchase of stationery)					

DR. CASH ACCOUNT Cr.

TO CAPITAL	50000	BY FURNITURE	15000
TO C'TANCY	25000	BY PURCHASE	5000
		BY M'STORE	2500
		BY SALARIES	5000
		BY STATIONERY	250
		BY BAL C/F	47250
	75000		75000

Dr. FURNITURE ACCOUNT Cr.

TO CASH	15000	BY BAL C/F	15000
	15000		15000

Dr. CAPITAL ACCOUNT Cr.

TO BAL C/F	50000	BY CASH	50000
	50000		50000

Dr. PURCHASES ACCOUNT Cr.

TO CASH	5000	BY BAL C/F	7500
TO M'STORES	2500		
	7500		7500

Dr.	CONSULTANCY ACCOUNT		Cr.
TO BAL C/F	25000	BY CASH	25000
	25000		25000

Dr.	SALARIES ACCOUNT		Cr.
TO CASH	5000	BY BAL C/F	5000
	5000		5000

Dr.	M/S MEDISTORE		Cr.
TO CASH	2500	BY PURCHASES	2500
	2500		2500

Dr.	ELECTRICITY & WATER ACCOUNT		Cr.
TO EXP.PAY'BL	500	BY BAL C/F	500
	500		500

Dr. EXP. PAYABLE ACCOUNT Cr.

TO BAL C/F	500	BY ELEC & WATER	500
	500		500

Dr. STATIONERY ACCOUNT Cr.

TO CASH	250	BY BAL C/F	250
	250		250

TRIAL BALANCE AS AT MONTH-END

PARTICULARS	DR.	CR.
CASH	47250	
CAPITAL		50000
FURNITURE	15000	
PURCHASES	7500	
CONSULTANCY		25000
SALARIES	5000	
ELEC. & WATER	500	
EXP. PAYABLE		500
STATIONERY	250	
	75500	75500

Dr. RECEIPTS & PAYAMENTS ACCOUNT Cr.
FOR THE MONTH

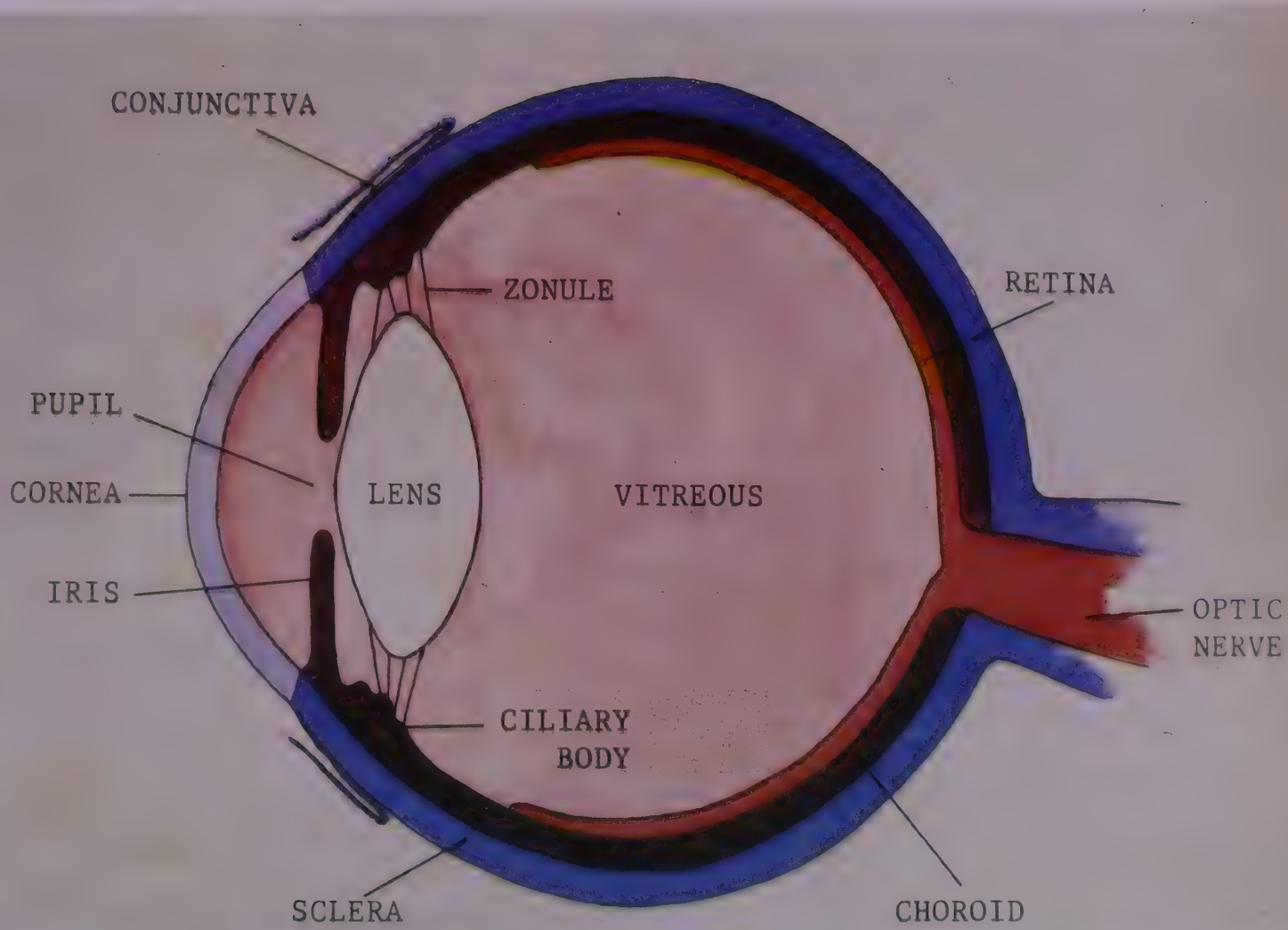
TO CAPITAL	50000	BY FURNITURE	15000
TO C'TANCY	25000	BY PURCHASES	7500
		BY SALARIES	5000
		BY STATIONERY	250
		BY CLOSING BAL	47250
	75000		75000

Dr. INCOME & EXPENDITURE ACCOUNT Cr.
FOR THE MONTH

PURCHASES	7500	C'TANCY	25000
SALARIES	5000		
ELEC/WATER	500		
STATIONERY	250		
EXCESS OF INC. OVER EXP.	11750		
	25000		25000

Dr. BALANCE SHEET AS AT MONTH-END Cr.

CAPITAL	61750	FURNITURE	15000
EXP. PAYABLE	500	CASH	47250
	62250		62250



Structure of the Eye

CLINICAL ORIENTATION

C.S.DHULL

VISUAL ACUITY

A. Recording Visual Acuity:

1. Pt. should stand 6 meters from the E Chart.
2. Close one Eye of the pt. with your hand and ask him to read the chart from above.
3. Ask him to tell in which direction the three legs go

B. Grades of Visual Acuity :

1. Good vision - 6/6 - 6/18
2. Poor Vision - 6/24 -6/60
3. Blind - < 6/60-Perception of Light/ No perception of light (PL/NPL)

CATARACT

What is Cataract ?

When Clear lens or its Capsule becomes opaque or milky, thereby decreasing vision by obstructing passage of light rays.

Causes of cataract :

Congenital .....Since birth
Traumatic .....Due to Perforating or Blunt injuries of the Eye.
Secondary .....Because of Eye or Systemic diseases.
Senile .....No definite cause is known

Usually seen after the age of 45 years.

Symptoms (Complaints of the Patient)

- Gradual painless loss of Vision in one or both eyes over months or years.

Examination:

- Grey or White pupil
- Measure the vision

Treatment of Cataract:

A. Congenital :
Traumatic : Needs referral to nearby Eye Hospital
Secondary :

B. Age related (Senile)

Surgical removal of opaque lens and provision of corrective glasses.

Methods

(i) Intra capsular cataract extraction (ICCE)
When whole lens and its capsule is taken out.

(ii) Extra capsular cataract extraction (ECCE)
When only lens is removed after making a window in the Anterior Capsule. Post. capsule is left behind.

Aphakia

Absence of lens from Eye - Surgical or after injury

Why Corrective Glasses are needed ?

After the removal of lens light will not focus on the retina giving rise to blurred vision. This removed lens needs to be replaced.

- Infront of the Eye - Spectacles
- In Contact with Cornea - Contact Lens
- In the Eye - IOL (a plastic lens at the time of operation)

Where treatment is available ?

- Eye hospitals
- Eye Camps

A close-up view of bilateral mature cataract. The left pupil has been dilated prior to surgery. Each cornea shows an abnormality over the inferonasal quadrant. This is climatic keratopathy not directly related to the cataract.

A mature cataract with the pupil in its natural state.

Case finding

- Screening of community by field workers with the help of PMOA's
- PMOA's should make list of cataract cases in each PHC

REFRACTIVE ERRORS

When rays of light focus either in front or behind the retina.

Types

(A) Myopia (Short sighted)

When rays of light are focussed in front of the retina. Usually seen between 5-20 years of age.

Symptoms (Complaints)

- Takes Objects nearer to the Eye
- Sitting very Close to black board in the class.

Treatment

- Minus glasses

(B) Hypermetropia (Far sighted)

When rays of light fall behind the retina

Symptoms

Usually seen in children

- Headaches & Eye Strain
- Difficulty in reading

Treatment

- Plus glasses

(C) Presbyopia

The lens is not able to change its shape due to weakness of muscles in the Eye. So light is focused behind the retina while reading. Usually seen near the age of 40.

Symptoms

Difficulty in reading, sewing or near work

Treatment

- Plus glasses

Case Finding

- School screening by PMOA's
- By teacher or Parents

Role of DPM

- Should plan regular school screening with the help of PMOA's/school teacher.
- Make provision of providing glasses to poor children from DBCS or NGO's.

GLAUCOMA

Glaucoma is an important eye complaint which is seen most often above 40 years of age. The commonest form develops gradually and, if left untreated, can lead to blindness.

Acute Glaucoma

Sudden rise of pressure is very painful condition and needs emergency treatment by eye specialist.

What Causes Glaucoma?

Usually caused by a slow increase above the normal pressure within the eye ball. As the pressure rises, parts of the nerve at the back of the eye are squashed and stop working.

Complaints

- Family history
- Gradual painless loss of vision
- Coloured ring around light
- Poor sight in dim light
- Unusual headache or eye ache
- Sometime no complaint

Treatment

- Medical & Surgical by Eye specialist

Vision Testing Chart

Trachomatis Scarring

Case finding

By screening above the age of 40 in PHC's/Hospitals/communities.

TRACHOMA

Repeated infection of conjunctive with Chlamydia Trachomatous.

Causes

Various environment factors favour trachoma :

- Poor hygiene
- Lack of water
- Seen in dusty & dirty areas
- Seen in families

Spread

It spread from one person to another through fingers, flies and common use of towels/clothes.

Treatment

- Medical & Surgical for complications

Prevention

- Health Education especially for pre-school and school children regarding daily face washing/bathing.
- Provision of clean water supply with the help of administration.
- Provision of proper disposal of excreta.

VITAMIN 'A' DEFICIENCY (XEROPHTHALMIA)

Dry eye due to vit. A deficiency may lead to corneal ulceration and blindness, particularly during the presence of measles infection.

Causes

- Less intake of vit. A rich diet
- Less absorption due to diarrhoea
- Increased demand of Vir. A during and after measles infection.

Complaints

- Night Blindness - Inability to see in dim light.

Examination

- Dryness of conjunctiva
- White foamy spots on conjunctiva
- May be corneal ulcer.

Treatment

- Giving Vit. A
- Treatment of Ulcer.

Prevention

- Encourage use of mother's milk, dark green leafy vegetables, Mangoes, papaya.
- Prevention of diarrhoea
- Immunisation against measles.
- Vitamine A supplementation

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VISION SCREENING IN SCHOOL CHILDREN

K.VAIDYANATHAN

LEARNING OBJECTIVE: To understand organisation and coordination of Vision screening programme of school children in the district.

STRATEGY: Utilising non - health sector manpower (School Teachers).

Refractive errors is the second most important cause for blindness at all ages. Ironically, they can easily be diagnosed and corrected. Majority of such patients visit the eye OPDs at the Govt. institutions or private clinics. Though the refractive errors are treatable and blindness due to these curable, the lack of awareness among rural populations, the accessibility to avail such care and availability of spectacles have led to large number of untreated cases.

Generally, in a population, the refractive corrections are required among children; in middle ages and to those who underwent cataract and or other surgeries. In this chapter, the emphasis would be only on refractive errors in children, particularly in school children. Why only school children?... A logical question. The answer to that is as given below:

a) Poor vision in childhood would affect the performance in their studies and could lead to lack of interest in studies and drop- outs.

b) School children are a closed group of population who could be organisationally easily identified and provided with proper services and

c) Primary Screening of Refractive Errors can be undertaken by trained school teachers. This will reduce burden of the Para Medical Ophthalmic Assistant (PMOA).

That is why this programme is called as School Eye Screening (SES) programme.

STAGES IN SCHOOL EYE SCREENING

1. Planning at District level

To start a SES programme, number of major and minor issues need to be attended to and prepared in advance. A project may have to have priorities and supportive cost to execute the same. In the District Blindness Control Society (DBCS) plan of action,

a) It would not be feasible to earmark all the resources and manpower to the SES programme alone.

b) Similarly, it would not be advisable to cover all the schools at the same time.

Selection of target group

Hence, *First*, it is important to decide on the managerial issues indicated above. By experience, it is possible to focus first in *middle schools* in a district or schools having 5th to 8th standards because :-

i) The age of the pupils would be around 10 - 14 and thus would be able to comprehend the purpose and need for such screening.

ii) Administratively it is easy to implement and provide better services as one teacher from one school would be able to handle about 150 pupils over a short period of say 3 - 4 months of one academic year.

iii) The number of middle schools in a block would also be manageable.

iv) The pupil would be able to carry home the message well and thus spread the awareness on eye care in their villages and towns better.

Manpower support

The second important step is to get the beneficiary list, namely, the list of schools, number of students in the focus group and the a list of teachers willing to get the skill oriented training to carry out this task in their schools.

Arrangement of Spectacles supply

Thirdly, identify suitable opticians by local tendering who would be able to provide required number of spectacles to the children at a pre-determined price, quality and time limit.

Materials Required

Finally, prepare a task sheet for each block in a district which should consider material production, training dates, diagnostics centres, monitoring tools and supply of spectacles logistics, the responsible person, and the cost calculations. Get them approved through a general body resolution at the DBCS meeting.

IMPLEMENTATION OF SES

The actual implementation of the SES activity involves basically three functionaries -the teacher, the PMOA and the Optician - each one needing clear understanding and coordination at block / taluka level. Given below is the flow chart for the SES in district, block and at school level.

At Teacher level

The Teacher need to be oriented on the methodology of diagnosis with the help of the kit that would be available with her / him through a standard skill development course for a day. (Details of training in the module). The training method could be a mix of theory, practicals, demonstrations, group discussions, question & answer session, course evaluation and review techniques. Once the training is over, the teacher is expected to conduct the actual exercise in his / her school only. The following points are to be understood by the teacher at school level for the better coordination of the project.,

a) He / She should get an updated list of target students in the school and enter them in a register. (suggested columns in annex)

b) Conduct the actual procedure as explained in the training and record the diagnosis in the register

c) Systematically follow the students for screening and for further referrals

d) Receive and distribute the spects for the needy and referred children from the PMOA / BEO

e) Ensure compliance and continuity of the programme in the years to come.

At PMOA level

The PMOAs should be able to provide the second referral points by organising the OPDs at fixed centres namely at the nearest PHCs in the block and communicate the schedule to the teachers during the training day itself. He should also channelise the spects requirements and supplies through the District Programme Manager (DPM) and cases needing further examination to the Ophthalmic Surgeon (OS). His / her major role is to organise

* Full diagnosis
* Prescription of spectacles
* Additional referrals if needed
* Placing of demand note for spects, receiving and redistribution at schools through local officials

* Follow up and data management
* Maintain register (as per coloumns suggested in annex) and report.

At DPM/OS level

The Optician orders, receipt and redistribution of the spects and its compliance need to be coordinated by the DPM. It is very likely that in the process of implementation, the feed back and base line information might get either delayed or ignored. It is therefore necessary to have a base register at teacher level, PMOA level and a master register at DPM / OS level. At the end of every month, the PMOAs and DPM should be able to evaluate the progress of each school and take followup action if needed. The Columns for DPM format is available in the module, P. 47.

THE OUTCOME

The SES programme could provide an excellent entry point to build the confidence and credibility of the DBCS and the NPCB in a district. It is likely, a better run and monitored programme in a district could cover the entire district in 2 - 3 phases over a period of 2 - 3 years; each year for a period of 2 - 3 months during Aug - Nov.,depending on the number of blocks, population and PMOAs fixed OPD centres.

Approximately, over 150,000 children could be screened during the phase and about 3500 spects could be provided by the DBCS.

The Community could get better awareness by propagating the eye care through the teachers and children with the help of the health education cards and by the actual provision of spects itself to the children. They are the real life examples of a credible service by the system.

EXERCISE

Following are the questions you should answer individually after the lecture is completed. Discuss with your faculty if you need more clarity in this lecture.

1. In case you wish to start a SES programme in your district, how would you sequence your action plan?. Give Number in order of sequence.

    * Select teachers
    * Make list of schools
    * Train teachers
    * Start screening in schools first
    * Organise supply of spects
    * Arrange refraction services

2. What criteria you would adopt to select teacher for this job?

3. How many teacher (s) you would select from one school normally?

4. Who are the persons essential in the training of teachers?

5. How long is the training for teachers and indicate your topics for training to teachers?

6. What is the distance between the teacher and the student during the eye examination & How does the teacher measure it?

7. What is the cut off level in the SES programme for considering the vision good?

8. How would you organise further referrals once the teacher finds the

9. How would you organise the supply of spects and ensure quality of it?

10. Who pays for the spects?

11. What are the major decision you would require to arrive at while planning the SES-project?

12. What are the three stages in SES ?

Columns suggested for Teacher register for SES

1. Sr. NO.
2. Name of student
3. sex
4. Age
5. Vision (RE)
6. Vision (LE)
7. Date screened
8. Date of receipt of spects
9. Date of distribution to student
10. Remarks

Monthly abstract for school
Month of reporting

	5	6	7	8	total
Total Students					
Students screened this month					
Students referred this month					
Spects received this month					

PMOA Register

Month of Reporting

Students screened this month

Students prescribed spects

Spects received this month

Spects distributed this month

Students referred for further examination

Students having other ailments other than refractive errors
Pl. list them with diagnosis

TRAINING MANPOWER FOR EYE CARE IN A DISTRICT ROLE OF A DPM - NPCB

R.C.SHARMA

As the number of avoidable and curable blind in India grows, the need for increased performances, under the programme for control of blindness, becomes more imminent and alarming. Increase in the performances and efficiency of the eye care delivery system will, in turn, be related to the knowledge, skills and motivation of the health manpower, responsible for delivery of these services.

Our country has a massive network of eye care manpower. The need of the time is, to ensure optimal and appropriate utilisation of this manpower, for the delivery of both quantitative and qualitative eye care services. The emphasis under the circumstances has to be on the analysis of performance gaps amiable to training and strategies to address these. This can, to a great extent, be achieved through tailor made and job related training packages.

Realising the importance of training, for providing appropriate eye care services to the consumers, the future strategy, of the National Programme for the Control of Blindness in India, envisages an important thrust to manpower development, in the coming years.

The process to start training activities, in an organised manner, on a large scale, started with a feasibility study on manpower development (August - Sept.'1993), sponsored by the Danish assistance to the National Programme for Control of Blindness (DANPCB), with the approval of Government of India. The study revealed, that training inputs are essentially required in three different areas of programme implementation i.e.management, cataract surgery and involvement of general health care staff.

The District Programme Manager - NPCB, has a definite role directly or indirectly, to ensure that the eye care manpower in his district is appropriately trained to contribute effectively for the implementation of the blindness control programme. He will be required to keep updated regarding availability of any relevant training and pursue the matter with the district authorities to depute suitable candidates, in time, as and when such opportunities arise. Role of the DPM in specific training activities, has been described in the relevant sections below.

MANPOWER FOR MANAGEMENT AT A DISTRICT LEVEL:

(a) District Programme Manager:

At the district level the main manager will be the District Programme Manager (DPM -NPCB), who has to work in close collaboration with the District Ophthalmic

Surgeon and the District Health Officer (or Chief Medical Officer) and the members of the District Blindness Control Society (DBCS).

The DPM is employed by the DBCS of which body he is the member-secretary as a full-time employee. He therefore falls outside the formal hierarchy of the NPCB and Government.

He is the coordinator of all blindness control activities at the district level and his main role is to bridge the gap between the need of the under served population on one hand and all resources that have to be orchestrated towards blindness control on the other. Since he has no formal authority within the GOI system his/her effectiveness will depend on personality, public relations and seniority. The same independence of the system may also grant him/her the flexibility to act quickly without being bothered by crippling procedures and red tape, leading to greater effectiveness of the DBCS in relation to blindness control.

The position has only recently been created and tasks can therefore only be described on the basis of the official job outline which is as follows.

Tasks allocated to DPM:

- Make situation analysis of the district
- Develop and implement plan of action for district
- Implement training
- Organise maintenance and repair of equipment
- Liaison with GOI, NGO's and Private sector
- Resource management, monitoring and reporting

If the selection criteria are adhered to as outlined above, the future DPM's will all have managerial experience. Expected benefits from training DPMs in these areas would be better management of human relations, essential for instance for mobilizing private eye surgeons or for obtaining permission and political support for organizing eye camps. Since the training is of short duration and exactly targeted at appointed functionaries, the benefits are expected to be noticeable soon.The DPM's will be stable in their job since they are not subject to transfers.

Training needs:

- Orientation to the NPCB and MIS.

- Managerial role to plan, organise, implement, monitor, coordinate and the NPCB in the district.

Duration: 2 Weeks

Venue: State Head Quarters or any other suitable institution

Methodology:

- A well prepared training schedule covering class room lecture discussions,exercises and case studies will be used. Areas like leadership, human relationship , management and organisation, community ophthalmology, conceptualisation of blindness control and NPCB should be adequately addressed.

- For procedural details regarding the functioning of DBCS the guidelines for DBCS(1994), developed by NPCB, Government of India, will prove very useful.

DPM's Role in this training:

After appointment it will be required that all the DPMs must undergo this training. This training is job related and will prepare him to perform his job appropriately. It will give him an insight into his day to day working and strengthen his capacities as programme manager.

(b) District Collector:

The District Collector (DC) has a crucial role to play as the formal chairman of the DBCS. This assignment is however only one of his many duties as a government official and the little time that he may devote to the cause of blindness control should therefore be used as efficiently as possible.

His main roles for the programme will be public relations, political support, liaising and mobilising of various resources. He is in a position to mobilise inter-departmental support and has the autonomy to make quick and collective decisions when provided with ready solutions and success stories. His position, does in most cases not allow him to spend time to discuss problems in the programme. Well prepared propaganda material on the programme will be needed to support the lobby.

Training needs:

Orientation to NPCB activities and functioning of DBCS

Duration: 1-2 Days

Venue: National or State level

Methodology:

- On joining as the chairman of the DBCS, the D.C. should be briefed on NPCB and functioning of DBCS by District Programme Manager. The DBCS manual prepared by DANPCB should be provided for reference

- May attend once, 1-2 days orientation workshop for DBCSs at state level

- VIP functions such as inauguration of a DBCS, being guest of honour at an eye-camp or an occasion of giving out rewards during Republic Day celebrations, are some alternative opportunities which should be used for briefing.

Role of DPM :

When a D.C. joins as the chairman of DBCS, the DPM should brief him at the earliest opportunity and also provide him with the GOI guidelines on the functioning of DBCS.

MANPOWER FOR SURGICAL SERVICES:

(a) Ophthalmic Surgeons:

Ophthalmic surgeons have a key role to play in the national effort to reduce blindness, especially in the reduction of cataract backlog. Around 350 post-graduate students follow courses in Ophthalmology as service candidates and private candidates every year. The team observed considerable variations in quality of the postgraduate training in ophthalmology during their visits to and discussions with faculty and trainees of various institutions. After completion of their training, these ophthalmic surgeons may take up any one of the following positions:

- Teaching ophthalmology in a Government or a Private Medical College with or without private practice

- District ophthalmic surgeon

- In charge, or being one of the members of a Mobile Eye Unit, engaged in eye camp work.

- General Duty Medical Officer in a PHC or CHC. Around 30% of GOI ophthalmologists are posted and work in non-ophthalmic positions resulting in non utilisation of trained manpower.

- Ophthalmic surgeon in private practice. Some may only be doing refraction work and medical ophthalmology, prescribing spectacles and contact lens. Others are

performing surgery as well..

The training needs for the common categories of surgeons in a district are discussed below.

(b) New ophthalmic surgeons and ophthalmic surgeons in non ophthalmic positions:

Fresh post-graduates and ophthalmologists coming from non ophthalmic positions, may need additional training in the following areas:

Training needs:

- The distribution of blindness, to understand the epidemiology of the problem and the relevance of the NPCB
- Basic diagnostic skills
- Efficient community ophthalmology
- Quality surgery (not necessarily high tech surgery)
- High volume cataract surgery
- Proper management of effective ophthalmic care
- Adequate orientation about the main causes of blindness

Duration: 8 - 12 Weeks.

Venue: Regional Institutes of Ophthalmology, Medical Colleges/ selected Non-Government Institutions.

Methodology:

- The above mentioned subjects should be covered to train the non active surgeons in ophthalmology and surgical skills.
- A refresher training in reputed eye institutions and well functioning Mobile Units can provide these ophthalmologists the necessary confidence

(c) Ophthalmic surgeon in a Mobile Eye Unit:

The ophthalmic surgeon leading a Mobile Eye Unit has to acquire managerial skills which can only be learned in practice. Quality control in eye camps is as important

as in the base hospital. There can not be a compromise in the basic conditions of asepsis, no touch technique and standard procedures. The magnitude of cataract blindness in India is so high that eye camps will continue to be necessary to provide surgical services in rural areas.

Training needs :

- Orientation to NPCB and MIS.
- Community Ophthalmology
- Managerial skills
- High volume cataract surgery

Duration: 4 weeks

Venue: Identified Medical Colleges and mobile units

Methodology:

- A prototype training package, comprising of sessions in classroom covering theoretical aspects (one week) and sessions in field and operation theatre (three weeks) will be developed and tried, after developing appropriate training materials.
- The ophthalmic surgeon leading a Mobile Eye Unit must acquire managerial skills, which can best be learned in practice.
- Regular review meetings with colleagues from other districts will help to learn from each other.

Role of a DPM

He should pursue the matter with the District authorities and ensure that the nominated surgeons join the training as and when notified.

(d) Paramedical Ophthalmic assistants:

PMOAs are initially trained for 18-24 months (six months in medical colleges / R.I.O., then in Mobile ophthalmic unit, district hospital and primary health centre)

PMOAs at present performs core tasks of primary eye care and refraction at Primary Health Centres. More than 4000 PMOAs are working in block level PHCs,

District Hospitals and Mobile Units. There are a lot of variations in the quality of basic training, quality of service provided by PMOAs when they are posted at the peripheral - level and the utilization of this cadre of manpower by the Eye Surgeons, Mobile Units, MO/PHC and the DHO. In some places they assist in camp Operation Theatre, giving facial and even retrobulbar anesthesia, while in other places, they are deliberately kept far away from active participation in eye care, which needs to be discouraged.

In the administrative setup, the MO/PHC is the immediate supervisor, at district level the District Health Officer. There is lack of technical supervision.

Training needs:

Basic training of the PMOAs seems to be more oriented towards Ophthalmic theory than practical skills to carry out core tasks at the primary eye care level. There seem to be performance gaps in core tasks of Retinoscopy and Refraction, primary eye care, Eye Camp work and OT procedures, which need short term in-service training. The training needs are specified below.

- Competency in recognizing and treating minor eye ailments, performs Vision testing, Retinoscopy, refraction and prescription of glasses.

- Diagnosing and confirming the suspected cataract cases, referred by health workers for cataract surgery. Assistance in preparation of operation theatre, facial block and post operative dressing under guidance of ophthalmic surgeons in eye camps.

- Assist in training of school teachers for school eye screening. Assist training of paramedical staff by District Training Team.

Duration: 1-2 weeks

Venue: District hospital or mobile units

Methodology:

- Continued in-service training of two weeks at the district hospitals and mobile ophthalmic units is being worked out. For this category members of the District training team will be Dist. ophthalmic surgeons , surgeon mobile unit, and senior PMOA .

Role of DPM :

In his capacity as programme manager, he will be required to organise this training in the district in consultation with the ophthalmic surgeons and DHO, when the training package is made available to him.

GENERAL HEALTH CARE STAFF

(a) Medical Officer Primary Health Centre (MO/PHC):

A medical graduate (MBBS) usually joins the Govt. service as M.O. PHC. At PHC he is responsible for provision of curative, preventive and promotive health care to a population of 20,000 -30,000. He is also responsible for planning, implementing and monitoring of National health programmes.The MO/PHC is trained in ophthalmology at the under graduate level, but, in most cases, does not have sufficient practical experience or confidence in handling eye disorders or diseases. The policy of the NPCB, has been to give a 2 weeks course in ophthalmology to all MOs IC/PHC. So far, that has hardly been implemented in the various states. The main reason is that the MO/PHC has so may other responsibilities and eye care is not the only priority. In view of this a three days training has been planned for this important category of functionaries.

Training needs:

- Updating on NPCB and his role therein. Supervision of PMOA.
- Brief overview of diagnosing, treating and referring eye cases.
- Working as a camp officer involving mobilisation of community resources and organising eye camps

Duration: 3-5 days (1 day at HFWTC, 1 day for eye camp and 1-3 days at eye hospital.)

Venue: HFWTCs (to be incorporated as a part of existing training or can be organised separately) /District Hospital/Medical College.

Methodology:

- A 3 days training package, consisting of a training module, simulation exercises and other components has been developed, field tested and will be used in Karnataka.
- The existing faculty of all HFWTCs in the country will be given orientation training at central or state level for using the training package.

Role of DPM: Ensure that the MOs are deputed and attend this training when announced.

(b) Block Extension Educators (BEE):

A BEE is posted at a block level and is responsible for providing extension education services in respect of national health programmes to the population of block (1 lac. approx.) He is a graduate and specifically trained in health education activities. At present he does not participate adequately in the blindness control programme in the country

Training needs:

- Orientation to NPCB, availability of eye care services and his role.
- Production and dissemination of health education and information material on NPCB. Dissemination of information about where and when of eye camps.

Duration: Two days

Venue: HFWTC

Methodology:

- A two days training package, including a module, guidelines on community diagnosis has been prepared and field tested by DANPCB.
- This can be incorporated in the existing reorientation training of BEEs at HFWTCs or used for conducting the training separately.
- Health education faculty of the HFWTCs will be oriented to the training package centrally.

Role of DPM: Ensure that the BEEs are deputed and attend this training when announced by HFWTC.

(c) Multipurpose Health Workers / Health Assistants, M/F:

After 12-24 (average 18 months) months training in health care at primary level, a Multipurpose Health worker male or female is posted at a sub-centre. He or she is responsible to provide primary health care to a population ranging from 2,000-5,000 (depending on area)

During basic training the health worker is oriented to NPCB for some time, but in practice the worker distributes Vitamin 'A' to under five children and provides initial treatment to cases of Conjunctivitis and Trachoma. It is noteworthy that, some other programmes have entrusted the female workers with technical tasks of considerable

complexity, including immunization,administration of ORS and insertion of IUD.

During the course of their service,they get promoted to position of health assistant or supervisor.

Training needs:

- Updating on NPCB and their role in the programme. Enumeration of blind in survey.
- Identify and refer suspected Cataract cases. motivation of cataract cases for operation in camps or hospitals as applicable.

Duration: 1 day

Venue: PHC.

Methodology:

This category of paramedical staff is proposed to be trained at the PHC by a District training team. For this training a training package including a training module has been developed by DANPCB. This training packages for paramedical staff can also be incorporated in the basic training of these categories as a revised input on NPCB.

Role of DPM in this training:

The DPM will be responsible for organisation and management of this training in his district. He will facilitate the district training team to carry out this training in all the PHCs of the district by rotation. He will provide the modules, ensure mobility, funds and also monitor the training.

OTHER MANPOWER

(a) Ophthalmic surgeons in Private Practice:

The ophthalmic surgeon in private practice may find that participation in eye camps as member of a Mobile Unit is in itself an enjoyable and rewarding exercise. It will also raise his standing in the community, will increase his dexterity and may help to increase his own practice.

Methodology:

The DBCS is the right body to approach these Private Practitioners for their involvement in blindness control activities in the district.

(b) Village level Workers:

A village level worker may be village health guide (VHG) or a trained birth attendant (TBA) or an integrated child development scheme (ICDS) worker. He or she may also be from any other department. This worker looks after approx. 1,000 population of the village and is very close to the community. He/she constitutes a very important link between the community and health system and as such can be utilised for NPCB activities, after proper training.

The existing village level workers (Health) are distributing Vitamin A to children under 5 and treating Red Eye.

Training needs:

- Orientation to NPCB and their expected role.
- Communication regarding eye camps.Suspect and refer cataract cases for confirmation and surgery,

Duration: One day.

Venue: PHC/Sector head quarter.

Methodology:

Training package developed by DANPCB for cataract case finding by workers can also be used for this category.

(c) Operation Theatre staff:

The existing practice of training this category of staff by attachment to an eye OT, for on the job exposure for assistance during eye surgery and nursing care to the operated cases,seems to work well, however training details for this category of manpower are being developed.

(d) Non Governmental Organisations:

There are many Non-Governmental Organisations, working in the field of prevention and control of blindness in India. Their presence and contribution differs in

every district. Some NGO's, notably CBM, Sight Savers, Aravind Eye Hospitals, etc. have their own training facilities, which are of excellent quality. Many of the smaller NGOs are dependent on others for training. With the establishment of District Blindness Control Societies, coordination and cooperation with local NGOs becomes much easier. Training courses for members of NGOs could be organised as per the needs.

Exercise:

Prepare a plan of action and time frame for the training of different categories of manpower identified by you.

Category	Total No.	Trg Inst.	Action by DPM	Dates/month

Other relevant information:

SOCIAL MARKETING FOR EFFECTIVE EYE CARE DELIVERY

R.D.Thulasiraj

WHAT IS SOCIAL MARKETING:

The use of the word "Marketing" is still frowned upon by the health providers, especially by those in the voluntary sector and those involved in the delivery of eye care to the community. Yet good marketing is the corner stone of effective distribution in business operations. As we define social marketing is, it is useful to dispel some of the misconceptions about this process and get a better understanding of what it is all about.

It is not:

* competing for the same patient through unfair means
* attracting patients by discrediting other services
* just health education

It is:

* a process of bringing about a social change which in this instance relates to changing attitudes towards health and health behaviour pattern

* a process of generating demand for health care services from the community from those who need health interventions but are not seeking it.

* a process of understanding the barriers to access and designing an eye care delivery system that addresses these barriers

(As an example) If the desired change is to make the population readily accept and come forward for cataract surgery, thereby ensuring that the eye hospitals are always working to full capacity and the eye camps are well attended, then we will need to do the following:

* **Understand their current perceptions about cataract:**

  - What is cataract and how is it caused?
  - Is it curable, if yes, how?
  - At what stage should it be operated?
  - At what part of the year should they get operated?

The above understanding should lead to the design of an IEC campaign that addresses the current perceptions and create better awareness.

* **Understand the current perceptions about the of services:**

  - Where can they get operated?
  - Are the services reliable and available as promised?
  - Do most people get good vision (as perceived by the community) following surgery?
  - Are the services expensive?
  - Is it painful and are they afraid of surgery?

Use this understanding to improve the quality of services and through an information campaign clear any misconceptions.

* **Understand the barriers to accessing cataract services:**

  - Logistics of getting to the Hospital or eye camp (getting transportation, finding an escort, costs, etc.)
  - Family support
  - Fear/intimidation of going to a big town or hospital
  - Money for meeting direct and indirect costs (transportation, food, lost wages, etc)

Based on this information, design a delivery system that addresses all these barriers and makes the services easily accessible and affordable.

This whole process of designing an information campaign (IEC) and designing a delivery system that make our services easily accessible, affordable and acceptable is the role of effective social marketing. In all the World Bank Project States, a beneficiary analysis was carried out to get some understanding of the above issues to design the project for the state as a whole. This information supplemented by some exploration at the district level can help in reshaping the service delivery strategy at the district level.

WHY SOCIAL MARKETING:

It is estimated that only about 5 - 7% of the total cataract blind in India gets operated in a given year. This is not entirely due to want of resources. In fact a macro analysis of resource utilization in India shows that

Surgeries per Ophthalmologist per year is	:	200
Surgeries per hospital eye bed per year is	:	13

One of the reasons has to do with accessibility of eye care services. The issues relating to accessibility starts with the process of creating awareness, motivation and finally delivery of eye care services with necessary follow-up. The process of creating awareness, or making relevant information accessible, needs a good understanding of

the patient population in terms of health behaviour, literacy levels, economic status, barriers to access and logistics of information transmission. This understanding helps not only help in the content but also in the delivery of the message. Similarly, in delivery of eye care services, while it is necessary to know about the clinical nature of eye diseases in the community it is even more important to know about the barriers to access. These barriers arise out of urban concentration of facilities, difficulties in travel logistics, lack of information, socio-economic constraints and health behaviour.

An analysis of the population of cataract blind as defined by the providers would indicate that a significant portion of them are not even aware of that the blinding condition is caused by cataract and that it is surgically curable. This indicates the need for effective health education input. Amongst the remaining who are aware about cataract and surgical intervention, a proportion is not willing for surgery due to reasons such as fear, family's attitude, religious practice, etc. Even amongst those who are willing for surgery only a small percentage gets operated while the rest are unable to have access for want of an escort, not knowing where to go, not having money or waiting for lens to mature. An operations research study[1] done in 1986 on a sample of 19,260 households from a population of 5 million in Madurai and Ramnad districts of South India, to asses the magnitude of the barriers, showed the following:

Reason for not undertaking cataract Surgery	Bilateral Blind (n=466) %	Unilateral Blind (n=786) %
No one to bring me to surgery	25.1	17.3
No need or desire for surgery	20.7	24.3
Unable to afford surgery	16.5	13.0
Afraid of surgery	16.5	13.2
No time to attend surgery	13.7	17.9
Do not know where to go	5.2	5.0
Able to see adequately	3.4	12.0
Cataract not mature enough	1.7	1.0

Barriers to access - Distribution of service facilities & Logistics:

Most of our population lives in rural areas, while the eye care facilities are predominantly concentrated in the urban areas. In the process of shift to urban areas, it is usually the young who migrate to earn a living, leaving the elderly in the village. Hence it is not uncommon to see villages with a higher proportion of elderly resulting in a higher prevalence of blindness in the rural areas. The data from the national survey[2] done in India in 1989 substantiates this. The projected prevalence of blindness (vision in the best eye < 6/60) in the rural areas is 1.62% while it is 1.03%; about 57% more in the rural areas. This higher concentration of blind in the rural areas further compounds the problem of male-distribution of services.

This presents problems in logistics with economic implications. Poor road infrastructure and public transport facilities makes travel difficult even for the sighted

persons and for the blind it presents a major problem. This is especially true in the mountainous areas of northern India wherein, several days of trekking is involved to reach the nearest road.

Barriers to access - Socio economic:

Eye care and cataract surgery is provided free or at a nominal charge in the government and voluntary non-profit hospitals. While the provider may provide the eye care services free, the patient has to incur substantial expenses to access the free eye care. There is the cost towards travel to the hospital for the patient. Quite often the patient requires a person to accompany because of the visual handicap. For this accompanying person, in addition to the travel costs there is issue of lost wages for the time away from work. In many situations they will need buy their food and some of the medications or spectacles. Sum total of these costs can be substantial for the people in this economic strata and this often inhibits the number of patients who can come for cataract surgery.

Barriers to access - Information:

The operations research study[1] also showed that in the control population the awareness about cataract and surgical intervention is less than 8%. While there is an increasing awareness with the advent of television and national programmes to control blindness, there is still likely to be a significant portion of the population still unaware about cataract and its treatment. This will need to be addressed in a very effective way through mass communication and effective intervention strategies.

Amongst those who know about the condition there are misconceptions that they have to wait till the cataract is mature or "ripe"; that they should not get operated in the summer months or monsoon season. Some of them don't know where to go for the services or how much it will cost them. These misconceptions and lack of required information leads to delay in accessing surgery and often not getting any intervention at all.

Barriers to access - Health Behaviour:

Traditional practices, beliefs, the patients fatalistic attitude towards blindness, fear of treatment, lack of faith in the intervention and, fear about the surgical procedures influence the behaviour of the patients leading low levels of acceptance. Health education, individual counselling and using operated patients as motivators, could help over come this problem. In the operations research study[1] it was seen that the aphakics had the greatest motivational impact, influencing over 33% of the cataract blind to accept surgery.

BENEFITS OF SOCIAL MARKETING:

The most direct benefit of social marketing is that we are able to reach more people who are blind and provide them with necessary services. Apart from this it also reduces the cost per cataract surgery thereby making it more cost effective and

affordable to who ever is paying for the services - government, donor or the patient. As a corollary to this the resource utilization also increases substantially. This can be best understood by doing the following exercise:

EXERCISE

Given below are the resources, performance and expenditures of a district hospital.

A. Infrastructure:

Facilities:

Beds	: 50
Operation Theatre	: 1

Staff:

Ophthalmologists	: 2
Paramedics	: 9
Housekeeping staff	: 6
Office & Security staff	: 6

B. Performance:

Out-patient visits	: 20,000
Admissions	: 600
Cataract Surgery	: 500
Other Surgeries	: 50

C. Annual Expenditure:

Fixed Costs:

Salary	: 420,000
Electricity	: 30,000
Maintenance	: 20,000
Other fixed costs	: 30,000
Total fixed costs	: 500,000

Variable costs (for cataract surgery only):

Suture, Drugs, etc.	: 60,000
Stationery	: 2,000
Instruments	: 8,000
Other variable costs	: 10,000
Total variable costs	: 80,000

D. Assumptions for allocation of costs:

a. Assume that 80% of fixed costs are incurred in providing cataract surgery
b. Assume that the variable costs shown is entirely for providing cataract surgery

Exercise - 1:

Work out the impact on cost per cataract surgery and resource utilization for the current performance level.

Calculating cost per cataract surgery:

Steps: 1. Fixed cost component per cataract surgery = 80% of Total fixed costs/500

2. Variable cost component per cataract surgery = Total variable cost/500

3. Cost per cataract surgery = Fixed cost component + Variable cost component

Calculating Resource utilization:

Steps: 1. Cataract operations per surgeon = Total cataract operations / 2
2. Cataract operations per bed = Total cataract operations / 50

Exercise - 2:

Assume different scenarios of patient load as given below and again work out the
a. cost per cataract surgery
b. resource utilization

Different scenarios of Cataract surgery load:
a. Current level of : 500 cataract surgeries per year
b. Increased level of : 1,000 cataract surgeries per year
c. Optimum level of : 1,500 cataract surgeries per year
d. Maximum level of : 2,000 cataract surgeries per year

a. Calculate Cost per cataract surgery at different performance levels:

Cataract Surgical Volume per year	Fixed cost per cataract	Variable cost per cataract	Total cost per cataract
500			
1,000			
1,500			
2,000			

b. Calculate resource utilization at different performance levels:

Based on your experience and through discussion establish capacity norms for the following to enable you to calculate the percentage of capacity utilization:
a. Cataract surgeries per ophthalmologist per year :
b. Cataract surgeries per bed per year :

Cataract surgery per year	Operations per bed		Operations per ophthalmologist	
	No:	% Utilization	No:	% Utilization
500				
1,000				
1,500				
2,000				

STRATEGIES FOR SOCIAL MARKETING

With this understanding of Social Marketing and its critical contribution to reducing blindness we can now look at some of the steps and strategies of designing and implementing an effective social marketing system.

1. Define priority areas (cataract, xerophthalmia, trachoma, school eye screening, etc.):

   As we will be dealing with limited resources, there is a need to decide on the priority to focus your efforts to diseases that are more important to your district. Depending on the prevalence various eye ailments and resources available, decide on the diseases that would be actively addressed. Do not come up with a long list. Be realistic in deciding on the priorities.

2. Define priority populations (rural, poor, children, etc.):

   Having defined the priority diseases, the next step is to define the priority population groups. Sometimes this is influenced by the occupance of the disease (e.g. Vitamin-A deficiency occurs in children) and at other times by accessibility of services as provided now (e.g. rural population has poor access to cataract surgery services)

3. Community involvement:

   Key to successful social marketing is active community involvement leading to community participation. This increases patient attendance, credibility of the programme and reduces the cost considerably as the community volunteers its services and quite often provides "in-kind" support.

4. Design and implement case finding and clinical service delivery strategies that reflect the priorities and takes into account the barriers:

   Some of the strategies for doing this are :

   - Case finding services at community level through eye camps and village volunteers
   - Partnership with the community for all outreach activities
   - Active use of aphakics (satisfied customers)
   - Patient education through patient counsellors, posters and banners
   - For screening eye camp patients free food and transportation to hospital and back.
   - Free surgery and stay

5. Monitor Patient satisfaction and visual outcome:

- Monitor accessibility and distribution of eye care services
- Periodically check visual outcome and sight restoration rates
- Periodically review quality and clinical procedures
- Assess patient satisfaction

These strategies will help in providing a large volume of services in a cost effective way. Strategies that pay attention to the problems of access of the patients can result in effective demand generation and when this is matched by cost effective service delivery systems, one can hope to make a major impact on the prevalence of needless blindness.

IEC Support for Blindness Control : District Dynamics

H.T.KANSARA

INTRODUCTION

Emergence of Blindness Control Societies empowers decision making at District level for all eye care activities, including those related to eye care information, education and communication. The District Programme Managers, therefore, have to acquaint themselves well with the methods and means of IEC. They have to perceive problems, project IEC needs, pool available resources and plan IEC activities to promote the cause of Blindness Control in their districts. This chapter on IEC specifically designed for training of District Programme Managers, attempts to analyze common issues concerning IEC intervention highlighting the role of DPMs in addressing those issues.

ROLE OF DPM IN IEC ACTIVITIES

The DPM may not necessarily be an IEC expert. Nor he himself may have to carry out any specific IEC activity save public relations to promote organizational image. His major tasks in relation to IEC would be:-

a) Set IEC Priorities

Cataract is the major problem. Various studies suggest that people by and large know 'cataract' as a problem of old age. They also know that operation restores vision. But hardly half of them are willing for operation. Even among those willing hardly 20% of them ever actually get surgery done of their own. The situation analysis of any district indicates that the huge number of cataract blind needs to be approached. So along, with the efforts to mobilize surgical resources, DPM has to initiate specific actions to mobilize people to enable them seek surgery to restore their vision. Hence the first priority for IEC in relation to Blindness Control would be to generate demand for cataract surgery.

b) Know the Problem

Then the question that comes to our mind is why so many people do not come forward for surgery ? The earlier studies referred to reveal the following reasons for poor response of the people to surgery.

1 Lack of information about services;
2 Lack of family support. The aged blinds dependence on family members, whose own priorities differ;
3 Lack of faith in service providers;
4 Lack of Motivation for vision restoration, due to very old age, other pressing health problem or past bad experience of self or others;
5 Fear of surgery;
6 Not in a hurry to get operated as the condition is painless and loss of vision

is gradual. Misconception that cataract can be operated only when total blindness sets in;

7 Seasonal preference of the patients for surgery.

One need not undertake an extensive study to know again what is already known. However, each one of these reasons need to be verified for local variations and addressed for proper IEC interaction.

HOW CAN IEC - INTERVENE ?

Systematic and sustained efforts to provide relevant information and education can influence the individuals, the families and the community as a whole. Our experiences in Pilot districts have a lot of information to share and the lessons to learn in respect of what, for whom, when, why and how of IEC input to generate demand for cataract surgery.

Know Your Target Groups

Although the end receiver of the messages on cataract is the patient there are many more who need to know and act. The target audience can therefore be grouped as under:

	Group	Characteristics		
1	patients	- Willing or concerned	indifferent	un-willing or conditioned
2	satisfied consumers	- Patients	care-takers	facilitator
3	facility-tours	- Service related	messages related	patients related
4	Providers	- direct	intermediaries	indirect

Develop Message Contents

Information/education capsules with core-messages and group-specific action messages have to be developed subject to area specific variations. Based on the studies and experiences the following core-messages have been conceptualized.

OBJECT	MESSAGE CONTENTS
Allay fears about operation	* Operation is safe, simple, within reach, affordable, and the only effective tool to regain vision. Many people have restored vision and have regained light in their life.

Influence beliefs and practices	* No need to wait for maturity of cataract. It is just removal of a clouded lens * It is safe in all places/all seasons, be it an eye-camp or hospital.
Appeal intellect	* To regain normal life, independence in mobility/daily living/work-ability.
Appeal emotions patients/caretakers	* See your loved ones are able to see again, are able to help you again, are back to work again.
Inform about services	* Dates and places of cataract surgical services, facilities offered etc.
Instructions about surgery	* Pre and post operative care including the need for wearing spectacles after operation to have workable vision.

Some messages for facilitator are also conceptualized as under:-

GROUP	OBJECT	CONTENTS
Facilitators like - village leaders - Health & other peripheral level workers - volunteers - Medical Practitioners	Enlist their involvement in cataract case-finding and in facilitating their reach to the service provider	- learn to find out cataract and to counsel them to avail services - earn blessings of the elderly - Goodwill of the community - Recognition from the providers
information dissemination channels, educators motivator	extend information and stimulate motivational process	All package of information blended with success stories
providers	consumer-response analysis	feed back on patient's expectations, aspirations and experiences

COUNT IEC RESOURCES

What resources from district to peripheral levels you can muster to reach your target groups with the desired information ? Let us first see them.

1 Are there any funds earmarked for IEC with your DBCS ? If not, the first thing would be to ensure what is provided for IEC activities. DBCS guidelines issued by the Ministry of Health indicates adequate funds for this purpose. Budget them in annual Plan with appropriate IEC activities.

2 What manpower do you have or you can lay your hand on to pursue your IEC objects? First see your own health system. The important staff members of health care delivery system include:
   a) Block level extension educators
   b) Peripheral Health Staff

c) Para Medical Ophthalmic Assistants

Given a little on the job training, these manpower resources can shoulder much of your IEC related jobs. Recognize their contribution suitably, not necessarily cash incentives. The experience in Tumkur (Karnataka) Pilot District indicate that even appreciation certificates and a pat on the shoulders do wonders. In fact, these grass root level workers do need some work that can earn them good name and fame. Cataract related work offers both.

3 Your own DBCS members are the most valuable assets and resources for your IEC related activities, particularly the representatives of voluntary organizations; a good rapport with them is however essential.

4 Another important resource that your DBCS has is the District Public Information department, which works directly under your DBCS Chairman. This department has an easy access to mass media i.e. local press, cinema and video parlors etc. All the pilot districts have very positive experience with them. Screening of cinema slides and frequent press coverage are exclusively their contributions.

5 In addition, there is one more organization (Central) that deals with field publicity and traditional performing Arts. Their jobs include plan publicity. Adequate support with this channel can be of immense help to promote interpersonal communication for cataract services.

6 Above all, DBCS Chairman being DC/DM District Collector the whole district administration would have a positive attitude to help promote information dissemination for cataract surgery. Basti in U.P. and Bhandara in Maharashtra have positive experiences of the immense help. The revenue and development staff provide to mobilize cataract cases.

SEE HOW YOU CAN DO IT ?

* Develop Logo of your DBCS. Logo of NPCB should also be used

* Ensure all communications from DBCS contain logo

* Make your DBCS known to all those in the district engaged fully or partially in eye care activities through a formal letter/pamphlets, press release or meetings/seminars etc.

* Seek their partnership for combined and concerted efforts

* Start some "entry point activity" that meets and instantly demonstrates, eye care related felt need of the people e.g. school eye-screening involving teachers.

* Publicize progress of such activities through local press.

Generate Demand for Cataract Surgery

* Chalk out common programme for fixed and camp-based cataract surgeries involving all concerned.

* Prepare programme schedule. Print it suitably in different formats like display charts; posters; letters; leaflets etc, Highlight-dates and places/of Screening camps/Surgical camps, facilities etc. ENSURE PRINTING OF LOGO ON ALL SUCH MATERIAL

* Display/distribute this informational material well in advance, with close eye to ensure their REACH in areas hitherto un-REACHED.

Supplement Information Efforts

* With oral communications like, Drum-beat and PA system

* With Panchayat and other organized channels like local Mahila Mandal.

Reinforce Information Efforts

Through peripheral health staff:

* Provide them with all programme material prepared

* Assign them specific area ACKNOWLEDGE THEIR EFFORTS

Provide Motivational Support

* Identify satisfied consumers from records of operated cases, capable enough to convey your messages. Appeal them to share their experience with others. Provide them with the above material giving information of your programme to enable them to refer new cases

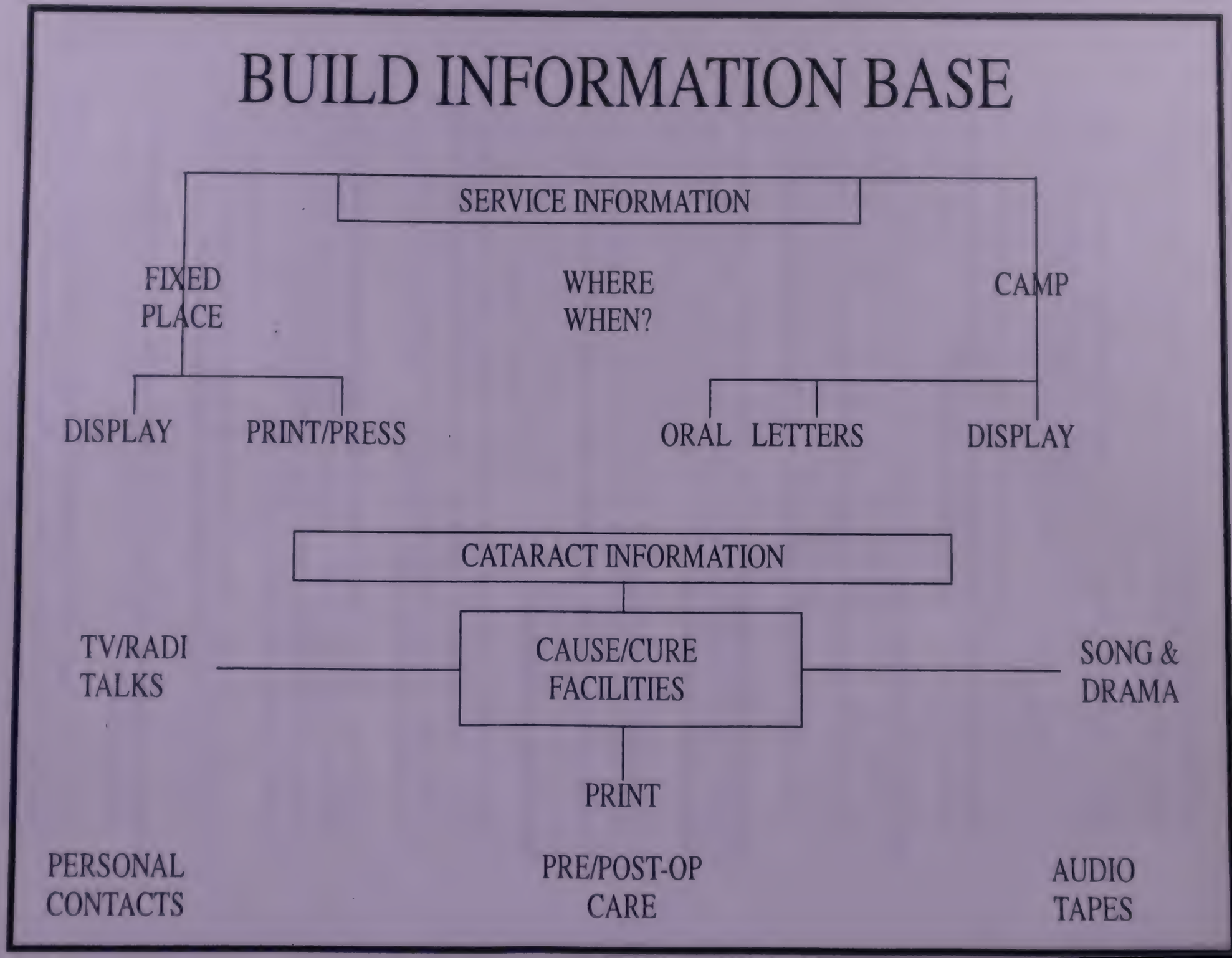
* Identify local resources that can help you lend these motivational elements in your information packages. Some of them are - a) District information system b) field publicity units c) Local song or drama talents d) Local press e) Local radio station f) Local video parlours if many

* Look for success stories, record them through audio-video or write them. Provide these success stories to the press or other information channels.

* See how information generates itself and multiplies to reach many with the messages intended

* Keep a close watch over any untoward happening. Incase if some such thing happens in an eye camp or a fixed facility that may give negative publicity then gather facts, appraise authorities, prepare positive report and publicize it with the concurrence of your DBCS chairman.

BUILD INFORMATION BASE



BUILD PROVIDER' IMAGE

DBCS

YOUR SURGEONS

QUALITIES

YOUR ORGANIZATION

ENSURES

FREE SURGERY

QUALITY

EASY REACH

COOD OLLOW-UP

CERTINITY

GREE SPECTACLES

BUILD PRODUCT IMAGE

CATARACT OPERATION

QUALITIES

AVAILABLE

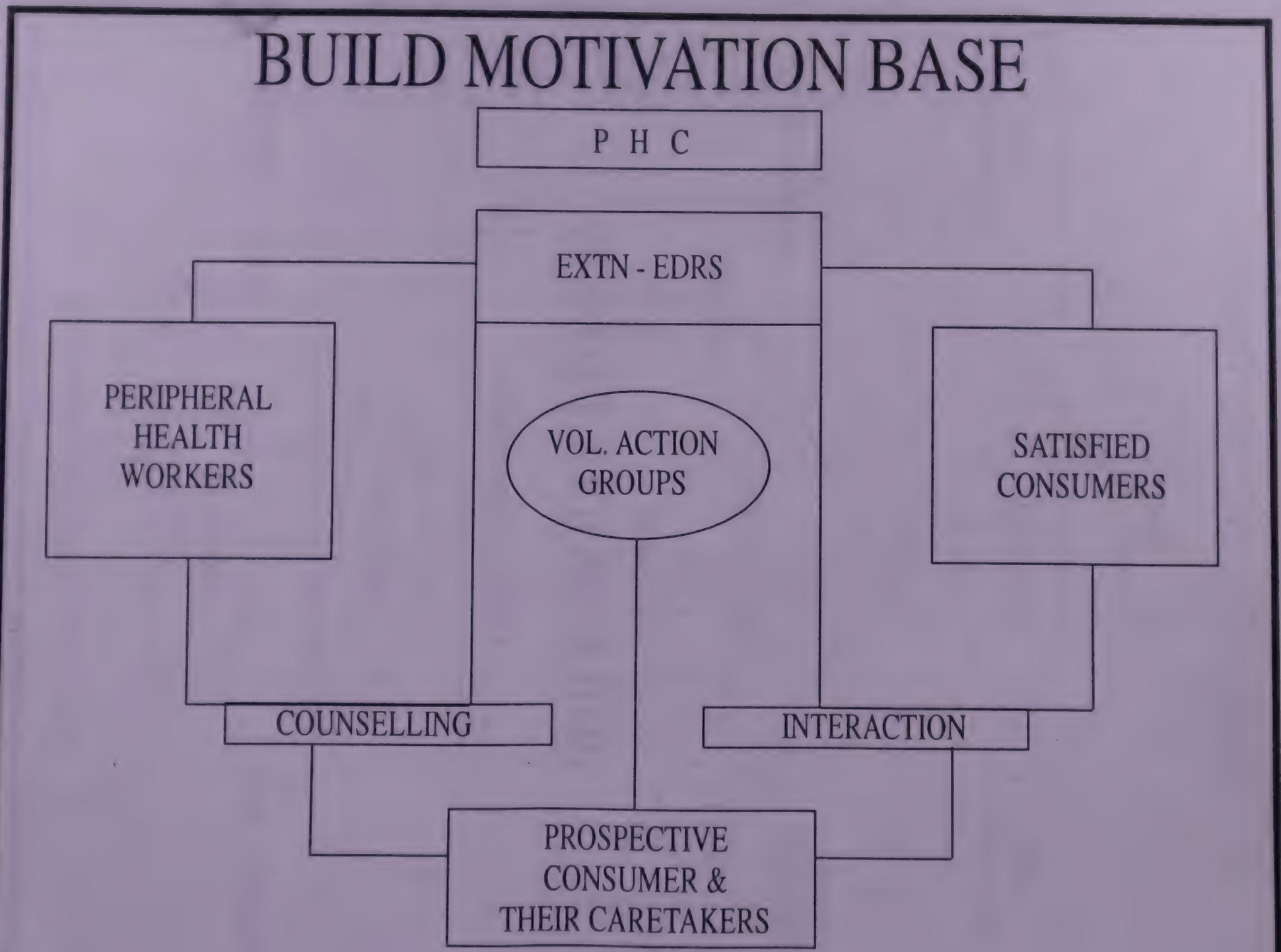
SAFE

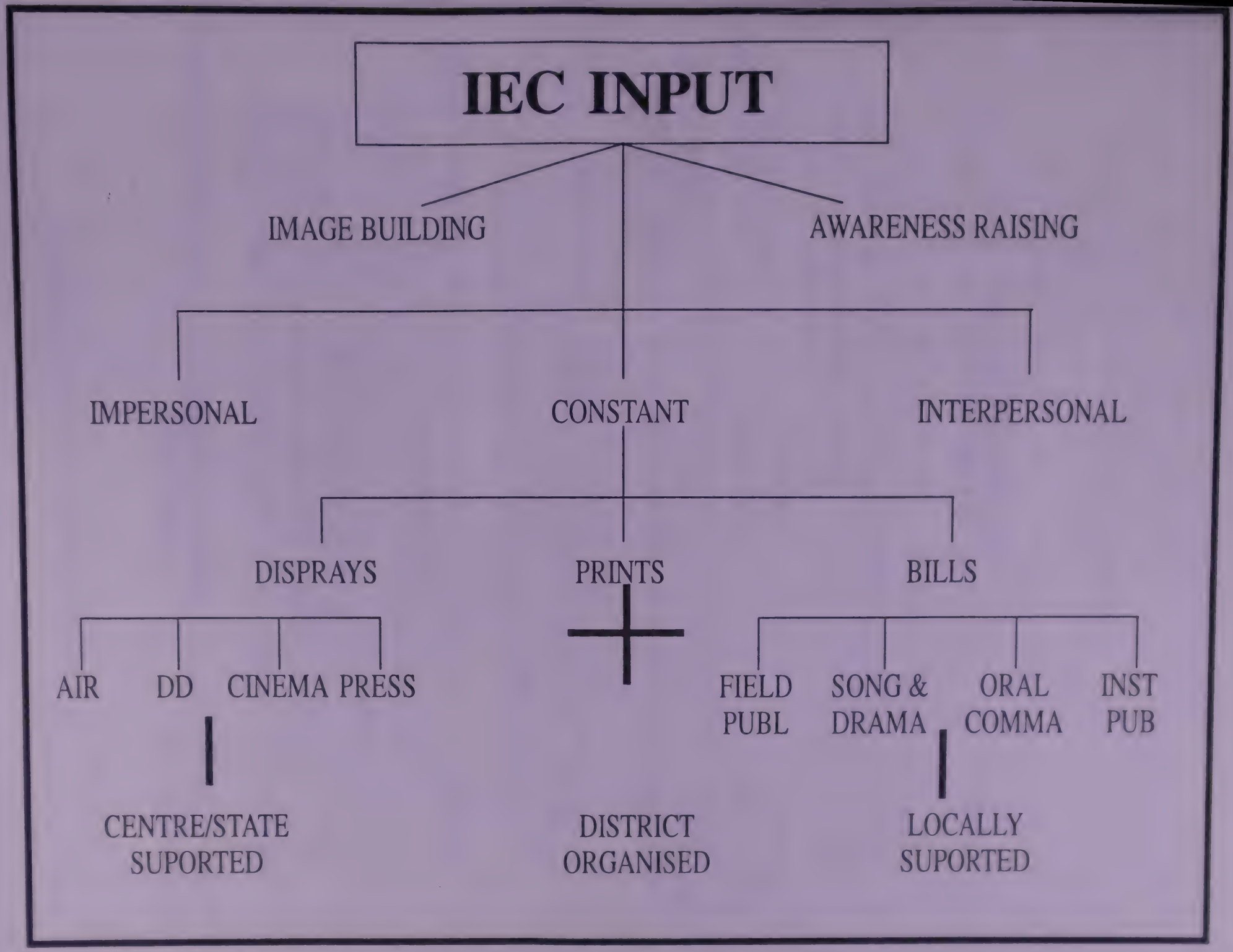
RESTORES VISION

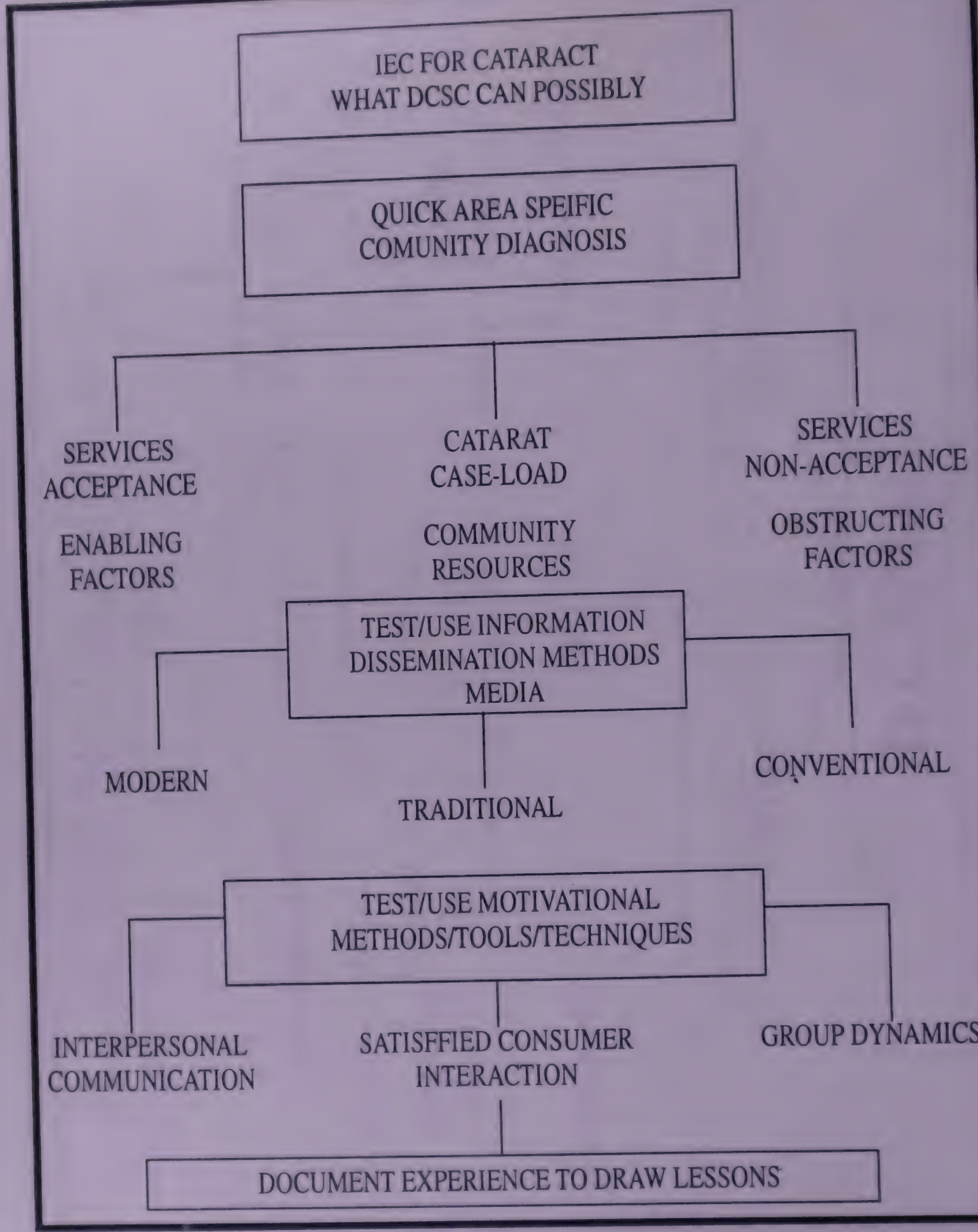
SURE

AFFORDABLE

MANY PEOPL HAVE REGAINED VISION


BUILD MOTIVATION BASE
P H C
EXTN - EDRS
PERIPHERAL HEALTH WORKERS
VOL. ACTION GROUPS
SATISFIED CONSUMERS
COUNSELLING
INTERACTION
PROSPECTIVE CONSUMER & THEIR CARETAKERS


IEC INPUT
IMAGE BUILDING
AWARENESS RAISING
IMPERSONAL
CONSTANT
INTERPERSONAL
DISPRAYS
PRINTS
BILLS
AIR
DD
CINEMA
PRESS
FIELD PUBL
SONG & DRAMA
ORAL COMMA
INST PUB
CENTRE/STATE SUPORTED
DISTRICT ORGANISED
LOCALLY SUPORTED


IEC FOR CATARACT
WHAT DCSC CAN POSSIBLY
QUICK AREA SPEIFIC
COMUNITY DIAGNOSIS
SERVICES
ACCEPTANCE
ENABLING
FACTORS
CATARAT
CASE-LOAD
COMMUNITY
RESOURCES
SERVICES
NON-ACCEPTANCE
OBSTRUCTING
FACTORS
TEST/USE INFORMATION
DISSEMINATION METHODS
MEDIA
MODERN
TRADITIONAL
CONVENTIONAL
TEST/USE MOTIVATIONAL
METHODS/TOOLS/TECHNIQUES
INTERPERSONAL
COMMUNICATION
SATISFFIED CONSUMER
INTERACTION
GROUP DYNAMICS
DOCUMENT EXPERIENCE TO DRAW LESSONS

PLANNING FOR EYE CARE SERVICES IN A DISTRICT

HANS LIMBURG

Planning is something everybody does the whole day through, although most of the time, one may not even be aware of it.

There are clear advantages in developing a planning process. When there is a plan, action is required by specified people and lack of action is soon apparent. With a plan, action is clearly defined with regard to specified problems and utilising specified resources and giving a specified time frame, and the outcome of the action can therefore be measured.

WHAT IS A PLAN ?

A plan is a course of action one intends to follow in order to solve a problem.

DO WE NEED A PLAN FOR PREVENTION AND CONTROL OF BLINDNESS?

Since so many people in so many areas are involved, we have to indicate clearly who is going to do what, where and when with regard to defined problems. Since a plan gives objectives, goals and targets, we can measure is effectiveness in alleviating the problem and its efficiency in terms of cost.

Planning is done at various levels. The methodology and objectives are similar in macro and micro planning, but the units are different e.g. in macro planning the district is the smallest unit while in micro planning the individual is the smallest unit. At the Central or policy-formulation level, a plan will cover the broad outline of what needs to be done and the resources that must be committed at the National level in order to enable policy objectives to be achieved. At the peripheral level, however, details of the actual tasks to be carried out, by whom and in which period, must be considered in the face of real everyday problems of resources and organizational difficulties.

The differences in planning at different levels is illustrated in Table-1

TABLE-1

CENTRAL LEVEL *Policy Planning*	Overall objectives; National inputs to achieve objectives	Example Increase no of eye Surgeons to 15,000
STATE LEVEL *Strategic Planning*	Objectives depend upon morbidity patterns; inputs to Districts to achieve goals	Which district needs additional eye surgeons
DISTRICT LEVEL *Operational Planning*	activities based on local needs; optimal utilization available resources	Posting of surgeon based on local needs

Planning at the periphery, district or community level, needs to be more pragmatic and less conceptual than at the National level. Although entirely different, planning at central and peripheral levels must not be considered as separate exercises because information from the periphery on effectiveness and efficiency is essential for policy planning by the centre. Similarly, National guidance and policy are also needed for peripheral planning.

Planning based on needs, identified at the periphery, is sometimes referred to as the 'Bottom-up' approach in planning.
In blindness control programmes, where the actual delivery of services mainly takes place at district and community level, the 'Bottom-Up' approach is the most appropriate approach in planning for prevention and control of blindness.

Till 1990, planning for the National Programme for Prevention and Control of Blindness has been done mainly at the Central level. In 1990, all States and Union Territories have prepared State Master Plans to indicate their goals and strategies for the NPCB. Similarly, District Blindness Control Societies are now preparing action plans for NPCB activities in their Districts.

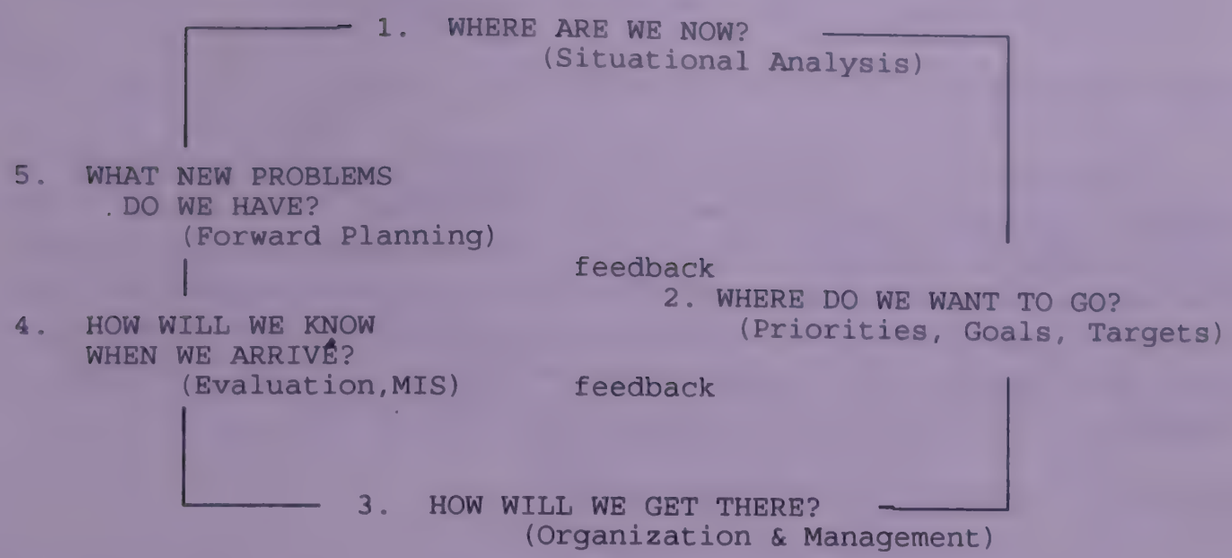
HOW DO WE MAKE A PLAN ?

Basically, the whole process of planning can be condensed to 5 essential questions which constitute the Health Planning and Implementation Cycle. This health planning and implementation cycle, which is shown in Figure 1 is described briefly below:

FIGURE 1

THE HEALTH PLANNING AND IMPLEMENTATION

CYCLE



WHERE ARE WE NOW ?

First, we have to know the problem we are dealing with. What is its magnitude? Who are affected? Where are these patients living? etc. We have to know the available resources of manpower, infrastructure and money to deal with this problem. With this information, we will be able to make a Situational Analysis (see previous chapter)

WHERE DO WE WANT TO GO ?

In a plan, one has to give objectives of what you want to achieve. Therefore, priorities have to be recognized and defined and goals and targets have to be set. These must be realistic, keeping in mind the available manpower, infrastructure and financial resources. We have to realize that in this phase, we use a lot of assumptions. For example, when the District Mobile Unit (DMU) is present in a district, we expect it to give a certain output in terms of cataract surgery performed. But when the DMU does not have adequate equipment or funds for POL, or when no publicity is done, the output will be low.

HOW WILL WE GET THERE ?

This part of the planning needs to be done in detail. Strategies have to be defined very clearly e.g. cataract operations in eye camps or institutional surgery, or both? Such a strategy decision can only be made if the capacity for cataract surgery of the available institutions is known from the Situational Analysis.
Who will do what, where and when? This depends on where your manpower

resources and infrastructure are located in the district. Task allocation is essential, but take care not to allocate too much work to some, and too little to others. Are the people able to perform the tasks assigned to them? Training programmes may be required and have to be included in the plan. Time schedules have to be defined. Organizational structures have to be established. A very essential aspect is supervision to ensure that the outlined strategies are followed and, if necessary, adjusted. This is where the actual management of the programme is taking place.

HOW WILL WE KNOW WHEN WE ARRIVE ?

Evaluation of the programme and the different programme activities is essential, not only at the end, but perhaps even more as an in-built activity of the ongoing programme. In this way it can give the essential feedback to check whether the objectives, goals and targets are realistic enough and whether the strategies chosen are effective and/or efficient and whether the organizational structure is adequate to ensure good management. To allow proper evaluation, you have to include a Management Information System in your planning from the onset.

WHAT NEW PROBLEMS DO WE HAVE ?

In the beginning of the planning process, we may have started with some assumptions.

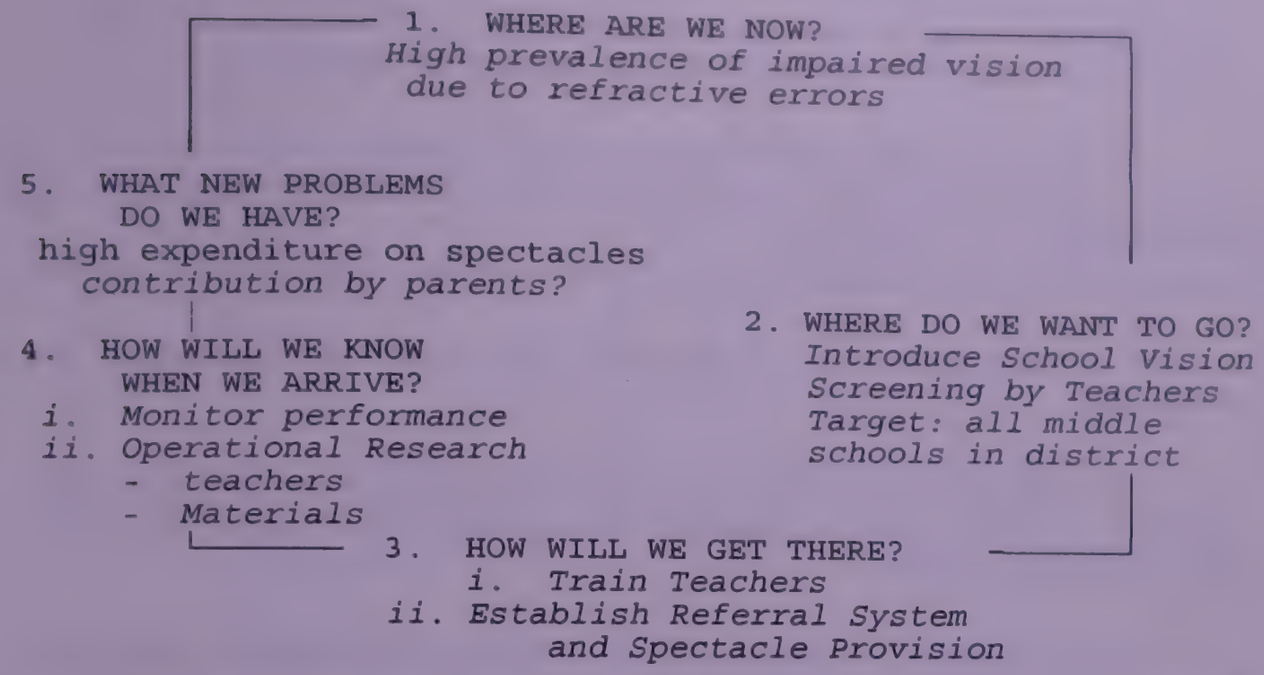
An example of such an assumption may be given: one of the strategies to prevent blindness is to provide a tonometer to Paramedical Ophthalmic Assistants (PMOAs) in PHCs so that they would be able to identify cases of glaucoma, refer them to the eye surgeons and prevent permanent blindness. The assumption is that all PMOAs know how to measure the IOP with a Tonometer, which is not always the case. Therefore, you may have a new problem: the inability of staff to be part of a screening programme for glaucoma. You will therefore have to plan for training sessions on how to measure Intra-ocular pressure.

Figure 2 illustrates the different steps in the planning process by using the example of School Eye Screening.

Planning is a continuous learning process, with a lot of emphasis on learning. Initially, we may start with a lot of assumptions, but gradually, during the process, we will learn more and more details which will give us a better insight and understanding and therefore allow better planning.

FIGURE 2

THE HEALTH PLANNING AND IMPLEMENTATION CYCLE
(AN EXAMPLE)


1. WHERE ARE WE NOW?
High prevalence of impaired vision due to refractive errors
2. WHERE DO WE WANT TO GO?
Introduce School Vision Screening by Teachers
Target: all middle schools in district
3. HOW WILL WE GET THERE?
i. Train Teachers
ii. Establish Referral System and Spectacle Provision
4. HOW WILL WE KNOW WHEN WE ARRIVE?
i. Monitor performance
ii. Operational Research
- teachers
- Materials
5. WHAT NEW PROBLEMS DO WE HAVE?
high expenditure on spectacles
contribution by parents?

Aims, objectives, goals and targets need to be constantly reviewed as the pattern of the health problems change, infrastructure expands, opportunities arise for more effective use of resources and the focus of priorities and policies are modified.

HOW DO WE START WITH THIS PLANNING EXERCISE?

The secret of proper planning lies in following the proper sequence. Compare it with a doctor, seeing a patient for the first time. The patient will explain his complaint, the doctor will ask all relevant information to assess the medical history of the patient and he will do a physical examination. This is the situational analysis.

Then the doctor may send the patient for additional examinations like X-ray or laboratory test, and only thereafter, he may arrive at a proper diagnosis and prescribe the appropriate treatment. Prescribing treatment, without a proper diagnosis, is not accepted as proper.

Equally in planning, we start with Situational Analysis. Format 1. could be of great assistance.

First, indicate the Eye Health Problem under consideration. This can be cataract, or Refractive Errors, etc. Then try to calculate the magnitude of this problem in actual numbers. (see exercise on Epidemiology of Blindness).

Thereafter, analyse in detail the present status, as far as case finding, treatment, follow-up and prevention are concerned. Indicate for each of these whether

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D15-330

you consider the present situation adequate or not. Be very frank here. You will not help anybody by stating that all is well, while it is not.

If you consider the present status adequate, there is no further action required. If you think further improvements are possible, indicate where the "bottlenecks", the constraints, are. For example, concerning Refractive Errors, you may find that case finding is not optimal, because you do not have enough PMOAs in the district to cover all the schools. The Bottleneck is then: shortage of trained staff.

An alternative approach could be to train teachers to screen children for refractive errors and only send suspected cases to the PMOA for refraction. This will save the PMOA considerable time.
Inputs required: training of teachers to conduct the screening, materials and guidance.

A similar analysis can be made for "Treatment", for "Follow-Up" and "Prevention".

If you have done this exercise for all the eye health problems, you have in fact translated eye health problems, identified in your Situational Analysis, into actions to tackle these problems.

You may find that you have identified so many problems, that it is impossible for your district to solve all of them in one year. Then it is important to prioritise the problems you have identified and decide which to tackle first and which at a later stage.

The second step is to transfer the "Alternative Approach" from Format 1 to "Activity" on Format 2. In the example above, it will be: increase case finding for refractive errors through screening by teachers. Sub-activities will be: make complete list of all middle schools in the district; select one teacher per school for training; prepare materials for training of teachers; train teachers, etc. Indicate what the output of each sub-activity should be, e.g. 30 teachers trained, when it has to be completed and who is responsible. It is advisable to make individual persons responsible, not "DBCS".

Also indicate how you can monitor that a certain sub-activity has really been done. For each main activity, arising out of format 1, you need at least one format 2, to identify and list all sub-activities.

The third step is to list all the sub-activities from all Format 2 forms and to mark the time when these have to be undertaken in the Time Table (Gantt Chart), Format 3. This is very helpful to ensure that you will have adequate time available for each activity and not all activities are clustered in one short period.

FORMAT 1:

EYE HEALTH SERVICES IN DISTRICTS: SITUATIONAL ANALYSIS

DISTRICT: EYE HEALTH PROBLEM:

ESTIMATED NO. OF PERSONS AT RISK:

ESTIMATED NO. OF CASES:

	PRESENT STATUS	ADEQ? Y/N	"BOTTLENECKS"	ALTERNATIVE APPROACHES	INPUTS REQUIRED
CASE FINDING					
TREAT-MENT					
FOLLOW-UP					
PREVEN-TION					

FORMAT 2:

WORKPLAN FORMAT

Activity: . . . . . .

Strategy: . . . . . .

SUB-ACTIVITY	Measurable output -numbers covered, Milestones achieved	Time Frame	Responsible person(s)	Monitoring Tool	Costs

FORMAT 3:

TIME TABLE

DISTRICT: DATE:

ACTIVITY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

SITUATIONAL ANALYSIS OF EYE CARE SERVICES AT DISTRICT LEVEL

Hans Limburg

Situational Analysis is about finding out what the health needs in a certain area are and what resources can be made available to take care of these health needs. In this chapter we will restrict ourselves to eye health needs.

The five key questions to identify the health needs in your district are:
WHO becomes blind? The young or the old? In cataract, the elderly persons are more affected, but in Vitamin A deficiency it affects the young children.

WHERE are people with eye diseases located? Very often ill health clusters in certain areas or communities. It may have to do with availability of food (fertility of the soil, water), standards of hygiene, socio-economic situation, etc. Vitamin A deficiency and Trachoma are typical examples of such diseases.

WHEN do people get eye diseases? Some diseases are seasonal, like viral conjunctivitis. Others, like cataract, glaucoma or refractive errors occur throughout the year. In certain areas, the provision of services, like cataract surgery in eye camps, is confined to certain seasons.

WHAT are the health needs? These can also be ranked in order of priority. Priority setting may be based upon outcome of the disease, possibilities for treatment, cost of treatment. Cataract is the main cause of blindness in India. Refractive errors are the second common cause. Trachoma has come down considerably and may only be a priority in some specific areas.

WHY does ill health occur? Why do some people fall ill, and others, exposed to the same pathogens, not? What is the importance of nutrition, personal hygiene, etc?

One way to find answers to all these questions is to do a survey. But in most cases in India, a lot of information is already available in the form of OPD records, 'eye camp registers, anecdotal information from ophthalmologists and PMOAs, etc. It is advisable to visit all units delivering eye care in your district and obtain direct information from them.

In order to identify the eye care resources in your district, you can apply the same methodology of the five key questions.

WHO is providing eye care in your district? Only doctors, or also PMOAs, NGOs, Private Practitioners or local healers? Where do people go for advice? What are the costs?

WHERE are eye care services provided? Most of the ophthalmologists are concentrated in the major cities. Eye camps are at present the only way to bring surgical eye care services to the villages. Are eye care services provided to 'risk'

groups?

WHEN is eye care provided? Are regular eye care services available? Emergency services? Are eye camps conducted throughout the year? If not, are surgical services available elsewhere?

WHAT eye care services are available? Is the quality of care adequate? Are people utilising the health care services? Are the services provided appropriate for the local needs?

WHY? What are the reasons that the eye care services are organised in a particular pattern?

Are there any other people other than health workers, who can act as resources for eye care? You can think of teachers, performing School Eye Screening programmes, school children doing publicity for eye camps, local volunteers assisting in eye camps, doing case finding of permanent blind persons for rehabilitation, etc.

There are also ample manpower resources with Non-Governmental Organisations and in the private sector. It is estimated that at least 50% of the cataract operations are performed outside the Government sector. Cooperation between the Government, private and voluntary sector can greatly improve the total performance.

Inter-sectoral cooperation with the education Department in School Eye Screening, with the Social Welfare Department in Rehabilitation, with Water Affairs Department in Trachoma control, with Agriculture Department to combat Nutritional Blindness, etc, is also essential for efficient and effective blindness control programmes. Through the District blindness Control Society, such cooperation and collaboration can be easily obtained. The Chairman of the DBCS (the District Collector/District Magistrate/Deputy Commissioner) is the ideal person to establish such links.

One can get a very good impression of the amount of work done by the different sectors by looking at their performance figures. Who is doing what and where in the district?

Resources for infrastructure and materials are essential. If buildings for eye camps are not available in the health sector, schools can be utilised. Occasionally, transport from other departments may be used, publicity can be done with the help of the Information Department, etc.
Is there adequate supply of surgical instruments, spectacles, drugs and sutures?

A detailed map with the main roads, indicating the eye care facilities in the Govt., the Voluntary and the Private sector in each taluka, is extremely important and should be made by each DPM for his or her district

A checklist for Situational Analysis is given in the annexure. It includes also general health and developmental indicators, to give an impression of the

developmental status of the district. The indicators for India are also given to enable comparison.

Data on population can be obtained from the Collectors office and the District Status Handbooks.

Health indicators for the district are usually available from the Chief Medical Officer / District Health Officer. Cataract operations done are also known to the CMO, but you may have to collect data from the NGOs and PPs yourself, since these are not always included.

The manpower and infrastructure resources are known to the Civil Surgeon and the CMO, but may require more research by the DPM, especially for the Voluntary and Private Sector.

EXERCISE:

To work out the appropriate target for cataract operations in your district, you should take into account the following factors:

- the number of operations required to bring down cataract blindness in your district
- the realistic capacity for cataract surgery in your district

	%		PERSONS
1. NEED FOR CATARACT SURGERY			
Population in your district:			. . . . .
Prevalence of blindness in your district:	. . .		. . . . .
Prevalence of Cataract Blindness: (= no. persons blind from cataract at certain point in time)	80%	(a)	. . . . .
Incidence of Cataract Blindness: (= no. of new persons becoming blind from cataract during the year)	20% of (a)	(b)	. . . . .
2. SURGICAL CAPACITY			
What is the capacity for cataract surgery in your district?			
Manpower resources:			
total no. eye surgeons (Govt., NGOs, PPs) (x700 operations per surgeon)		(c)	. . . . .
Infrastructure resources:			
total ophthalmic beds (Govt., NGOs, PPs) (40 operations per bed per year)			. . . . .
Ophthalmic Mobile Unit present? (2000 operations/year per O.M.U.)			. . . . .
Total infrastructure capacity:		(d)(+)	. . . . .
3. ACTUAL PERFORMANCE			
Quantity:			
How many cataract operations were performed in your district last year?		(e)	. . . . .
Quality:			
How many cataract blind persons regained sight?		(f)	. . . . .
4. LAST YEARS TARGET		(g)	. . . . .

What are your conclusions, when you are comparing a, b, c and d with e, f and g? Is your district target realistic, in view of the needs and the resources? What inputs does your district need to perform optimally.

MANAGEMENT INFORMATION SYSTEM FOR NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

DAMODAR BACHANI
HANS LIMBURG

Learning Objectives:

At the end of the session, the trainees should be able to:

1. Understand the concept and mechanism of MIS
2. Understand the MIS in relation to NPCB
3. know the method and periodicity of collecting information from data generating units in the district
4. fill up standard formats available and forward these to various offices
5. use data locally in monitoring the activities and in drafting annula plan of action.

Introduction:

Collection, compilation and analysis of useful information is an integral component of the implementation of a programme. It is a strong management tool that guides the implementors about setting priorities, alter strategies and assist in self-appraisal. A strong, uniform and efficient Management Information System would also be helpful in planning process at all levels, allocation of resources and evaluation of the programme.

An efficient MIS would include easy collection, timely and regular flow and prompt utilization of data in a standard manner. It should collect and forward only relevant and useful information in the system at various levels. There should be mechanism of feedback as well.

COMPONENTS OF MIS

There are three components of Management Information System; Date Collection, Data Flow and Analysis & Evaluation.

1.Information Collection

It has to be decided WHAT information is to be collected, WHY, WHO will collect it, from WHERE, which reporting units and WHEN, at which time intervals. The data collected has to be appropriate and relevant to provide answers to the problems posed, it has to be accurate and of good quality, and it should be feasible to collect these data, without too many efforts or costs.

The temptation is great to ask much and detailed information from the reporting units. This often result in incomplete and inaccurate reporting, delays in data flow

and even more delays in data analysis, evaluation and feedback. When the amount of data is too large, analysis and evaluation becomes impossible. The Management Information System, which purpose is to translate information into action, has then been reduced to a mere Information Collection System.

At present, only data pertaining to cataract surgery are collected from the districts. Some districts do provide a differential performance for each unit, NGOs and Private Practitioners providing surgical services. Type of surgery, outcome of surgery, etc, are not given.

It is intended to collect much more data to enable adequate monitoring, evaluation and management of all aspects of the project. Part of these data will come from a regular monthly MIS. Other data will be collected through surveys, rapid assessment or special studies.

2. Flow of Information

The data have to go to a central point for analysis and evaluation. The Data Flow has to be timely, without any delays, and as complete as possible. With the minimum required data collected, delays in data flow will be least.

Today, every district in India is linked with the State headquarters and the Centre through electronic media, NICNET. The MIS for the NPCB could be linked with the National Health Management Information Centre for fast and safe data transfer.

3. Analysis & Evaluation

Finally, analysis and evaluation has to be carried out. Here again the questions arise WHAT to evaluate and WHY. WHO will do it, WHERE, at the district, State or National level, and WHEN, how frequently.

LEVELS OF MIS

It is important to realize that the requirements for monitoring, evaluation and efficient management are different at all these three levels. Therefore, the level at which monitoring and evaluation is done will determine the type of data collected, the reporting units, intervals, etc.

Performing Units (MIS level 1)

Data would be generated at the level of RIO, Medical College, District Hospital, Camps, CHC, NGOs and private institutions and practitioners. Information is to be collected monthly from performing units

District Level (MIS level 2)

At district level, one would like to know who is providing eye care services in the district and to what extend. Is all manpower and infrastructure well utilized? Are

there any constraints in manpower or infrastructure in the district? Are all taluka's covered equally or are any area's neglected. How is the turn out of patients at the camps. Are there any seasonal trends? If yes, what are the reasons for that.

State Level (MIS level 3)

At State level, one would be more interested in the performance of the individual districts and the trends over the last few years. The state may like to monitor which district may need additional manpower or infrastructure to cater for the eye care needs. The state may like to know which type of eye care unit, hospitals, mobile units, NGO's or Private Practitioners, are delivering eye care in and efficient and effective way.

National Level (MIS level 3)

At National level, the programme managers may like to know how the individual states are performing. Which strategies are effective in increasing the output of the programme and which are not effective. Whether the number of sight restoring cataract operations is enough to reduce the backlog of cataract blindness in the country. With the central supply of ophthalmic equipment and vehicles, they would like to have yearly updates on the status of equipment and vehicles.

USE OF STANDARD FORMATS

Standard formats have been framed for compiling the information at the district level and forwarding it to MIS level 3 to the State and Central authorities. Use of Standard Cataract Card would further help in collecting useful information on operated patients. Formats for collecting information from data generating units like district hospitals, mobile units, private surgeons would further help development of MIS. These formats have been developed keeping in view current requirements and present status of MIS. With computerisation of MIS, changes would come for which District programme Managers should be prepared. However, the ficus is on collecting minimum relevant information at various levels. It may not be necessary for central authorities to know which PHC or block is performing badly. But it would be very vital information in planning the programme at the district level.

Standard formats currently in use have been annexed in "Guidelines for DBCS" These should be regularly sent as per suggested guidelines.

Proforma A: This is regarding organizational setup of the DBCS. It should be sent at the time of setting up the DBCS and in the month of April, every year even if there are no changes in the structure. In addition, if there are changes in names of Chairman (District Collector), District Ophthalmic Surgeon and District Programme Manager (Coordinator), these should be conveyed immediately.

Proforma B: This is regarding infrastructure and manpower available and developmental activities undertaken. This proforma should also be sent

every year in the month of April.

Proforma C: This is regarding performance by various units in the district during each month of the year. It also relates to expenditure incurred by the DBCS. This is the most important proforma and should be sent quarterly in the months of April, July, October and January every year. If these are sent regularly, it will facilitate release of recurrent funds in time. The information is to be collected on a monthly basis but forwarded quarterly. In addition the Audited Statement of Expenditure and Utilization Certificate should be sent annualy not later than 30th June of the year.

Proforma D: This is regarding Taluka/block-wise cataract performance. It would help in planning and management of services within the district. It should be sent quarterly along with Proforma C.

EXERCISE 1: SEASONALITY IN PERFORMANCE

Cataract Operations performed in two districts in a given year are given hereunder:

Month	District A	District B
April	234	359
May	212	335
June	196	347
July	204	240
August	223	458
September'	235	659
October	356	535
November	590	472
December	654	482
January	598	403
February	554	584
March	660	572
Total Catops	4716	5446
Population	25 lakhs	23 lakhs
Catops/lakh population	_____	_____

1. Comment on the seasonal performance in the two districts.

2. What information would you need to find out reasons for seasonality?

3. What interventions would you suggest to minimize seasonal variation and increase output?

4. Calculate Cataract Operations performed per lakh population in the two districts and comment.

EXERCISE 2: ASSESSING THE PERFORMANCE OF VARIOUS UNITS

Study the performance of a district for a given year.

Month	Cataract Operations Performed			
	Distt.Hosp.	DMU	NGOs	Private Practitioners
	Beds=30 Surgeons=2			Beds=60 Surgeons=6
April	34	0	120	18
May	27	382	119	54
June	42	56	0	34
July	41	263	136	15
August	18	196	0	25
September	29	142	201	20
October	32	230	0	30
November	22	240	0	22
December	29	288	291	25
January	27	278	0	25
February	26	324	0	24
March	28	330	300	26
Total Catops				
Catops/Bed				
Catops/surg.				

1. Comment on the performance of various units in the district

2. Calculate the performance of each unit by Catops/ophthalmic bed and comment.

3. Calculate the performance of each unit by Catops/surgeon and comment.

4. Discuss with the course facilitator possible reasons for suboptimal performance and suggest ways to improve performance.

EXERCISE 3: ASSESSING THE PERFORMANCE IN VARIOUS BLOCKS

BLOCK	POPULATION	Apr.	May	June	July	Aug.	Sept.	Total in 6 months	Catops per lakh pop.
A.	1957	159	115	144	136	160	152		
B.	3871	92	32	34	85	43	83		
C.	1683	40	36	34	35	20	16		
D.	2387	114	100	101	60	40	50		
E.	2837	21	49	23	29	34	67		
F.	2353	1	4	4	3	12	86		

1. Calculate total catops performed in first six months in each block.
2. Calculate catops per lakh population in first six months in each block
3. Name blocks performing well in the first six months
4. What would you suggest to improve performance in remaining 6 months.
5. What should be target of catops in remaining six months in each block and in the district as a whole so that the district does not add to the backlog?

EVALUATION OF THE CATARACT INTERVENTION PROGRAMME IN A DISTRICT

RAJ KUMAR

INTRODUCTION

Evaluation is a process which attempts to determine the relevance, effectiveness, efficiency and impact of activities in the light of specific objectives. To evaluate means 'to ascertain the value or worth of', according to its Latin root. In simple words, 'evaluation' means periodically assessing the programme's progress towards its objectives.

Evaluations, though usually retrospective, are essentially forward looking with regard to their purpose. It is an action-oriented management tool for improving both current activities and future planning, programming and decision making. Evaluation can be an excellent tool as well as means to accelerate programme performance and demonstrate accountability. It can be used in advocacy to obtain greater support from government, private & voluntary organizations, and general public.

Purpose of this guide

This guide is a step-by-step instruction manual with sample exercises designed specifically to evaluate cataract intervention programme in a district. All the 5 steps can be carried out by someone with no previous planning or evaluation experience. Though the guide is targeted for use by the District Programme Manager or DPM (NPCB), it will also be found useful by a State Programme Officer (NPCB) for evaluating the programme in the entire state. Alternatively, any other manager, programme officer or a research worker interested in analyzing a large scale community based cataract intervention programme will find the steps described easy to follow and helpful. What all is required is a simple pocket calculator and GOOD AND RELIABLE INFORMATION/ DATA.

Steps of evaluation

The evaluation of cataract intervention programme in a district should be able to answer the following questions, described in 5 logically arranged steps in this guide in the following sequence:

1. What has been the programme performance compared to previous years ? Has it gone up or down ?

2. How is this output of cataract surgery related to what is expected to be done i.e. target (explained later) ?

3. Are all the constituent talukas/blocks in the district equitably covered ?

4. Are the critical resources in the district adequately utilized i.e. Ophthalmic Surgeons (OSs), available ophthalmic beds, mobile ophthalmic unit or eye camps?

5. Is the quality satisfactory - of services to the programme, and of sight restoration to the operated persons ?

For the evaluations to be complete, each of the above 5 questions should cover the following aspects:

a) What happened and how does it compare with what was expected? This will include comparisons with the experiences in the past, the targets or the prescribed norms.

b) Why did the expected outcome did or did not happen ? The reasons can, at many times, be gathered from informal discussions with service providers and other people in the district.

c) What should be done about it ? It is likely that practical solutions are possible for most of the reasons identified; it may not be the case for some problems, where alternatives should be considered.

What not to evaluate

It is not necessary to evaluate the scientific basis or comparison amongst the various approaches to cataract surgery - ICCE or ECCE, IOL or aphakic glasses. These are purely research issues.

When to evaluate

Once a year, preferably during the months of March and April, before the action plan for the following year is finalized. At the most, that too if felt necessary, a mid year evaluation around September or October can be carried out. Any temptation to carry out more frequent evaluations should be resisted since it will not be possible to incorporate frequent changes in the planned or ongoing activities.

Secondly, the evaluation will be meaningful only if substantial programme related activities have taken place in a district during the year under reference.

Correct and reliable data in a district is a prerequisite for good evaluation

ANNUAL OUTPUT OF CATARACT SURGERY

Cataract is an universal disease, directly related to old age. Due to a continuous rise in population size and life expectancy, the needs for cataract surgery in a district

goes up every year. Therefore, the output in terms of number of cataract operations in a district should demonstrate an increasing trend over the years. It has been observed in the 5 experimental districts that there is an improvement by 50% atleast in the first year of accelerated intervention after which it may continue to go up by 10 to 20% every year. Any district showing stagnant or lowered performance for 3 years continuously should cause concern as it indicates poor output on account of underutilization of the available resources; or rarely, other factors like reaching of a plateau after which further increase is possible only if additional resources/infrastructure is provided or an existing strategy changed to a more efficient approach.

The first calculation a DPM has to do is to compare the current year's performance of the district with that of previous two years.

EXERCISE 1

Given on the following page is the table of output of cataract surgery in Tumkur and Chickamaglur districts in Karnataka state for last 3 years. Compare and contrast the performance of the two districts. You may wish to draw a bar diagram to illustrate your answer.

Year	Tumkur	Chickamaglur
1991-92	2497	3428
1992-93	5426	2464
1993-94	5446	1060

Do the same exercise for your own district and evaluate how well it has been doing over the past 3 years.

MEETING THE TARGETS

The next step for a DPM to evaluate is how far the needs or the targets of the district were met during the preceding year. For evaluation, the programme objectives are required to be broken down into smaller operational components, known as **Targets**. These are in form of measurable indicators, either as quantities (or numbers) or milestones. For example 'Perform 60000 cataract operations during 1994-95' is a quantifiable target, whereas, 'Supply eye camp calendars to all PHCs during June' is a milestone target.

The present practice that each district is allocated a certain target mentioning the number of cataract operations to be done during the year, depending on its past

performance and the expected potential. Very little attention is paid on the actual **needs** of the district or the **feasibility** of achieving these with the available resources. However, it is more appropriate that the targets are estimated keeping in view the needs of the district and the available resources rather than arbitrary allocations. Similarly, evaluation should be able to answer to what extent the 'actual needs' of the district are being fulfilled by the current surgical output.

How to calculate the target

The incidence of cataract blindness is 'believed' to be 2 per 1000 population, indicating that this should be the minimum output for cataract surgery in a district (there are lot of assumptions in this, but for sake of simplicity we will avoid the details). And in addition, we wish to reduce the backlog and perform operations for the second eye operations and the unilateral cataracts. The minimum output in a district, therefore, must be in the range of 2.5 to 3.0 per 1000 population. It will be higher if the backlog of the cataract operations is planned to be tackled in a shorter period. So to start with in your district, it is essential that individual targets are worked out irrespective, of what has been allocated by the NPCB or the state.

EXERCISE 2

Estimate the target for your own district and record how it compares with the allocated target.

The population size of the various districts in India is highly variable and, therefore, comparison of absolute figures amongst the districts can be erroneous. The same is true of various talukas within the same district (discussed later). On the other hand, there is little variation in the prevalence or incidence of blindness due to cataract. Therefore, output of cataract surgery per 1000 population in a district is a more sensitive index for evaluation. It is a better representative of performance than the absolute figures. This point will become more clear after attempting the following exercise.

EXERCISE 3

In the last exercise, you compared the performance in terms of the total number of operations done in a year in Tumkur and Chickamaglur districts of Karnataka. Now estimate the cataract surgical output per 1000 population for the last 2 years for these districts and compare the performance again.

	Tumkur	Chickamaglur
Population (lakhs)	23.06	10.17
1992-93	5426	2464
Rate per 1000 pop	____	____
1993-94	5446	1060
Rate per 1000 pop	____	____

Does this analysis change your opinion about the performance of cataract surgery in these two districts.

Calculate the cataract surgical output for your own district for the last 2 years. How does it compare with the targets you worked out before ?

Year	Surgical rate per 1000 population
1992-93	____
1993-94	____

EQUITY OF COVERAGE

The next question an evaluation should answer is whether all the constituent blocks/talukas in the district have been equally covered. Normally it is practice that the services, both in hospitals and eye camps tend to cluster around a few places within the district. And this information usually goes unnoticed. When the analysis about the surgical output is done separately for all the blocks/talukas, the DPM gets sensitized about the blocks/talukas where the coverage is low and more eye camps are required in future.

EXERCISE 4

There is evidence that Tumkur district has done tremendously well in conducting eye camps and organizing other services for cataract blindness during the past 2 years. The Ophthalmic Surgeons opine that not many operable cases are left in the district. Unconvinced with such an opinion, the DPM of Tumkur decides to do a taluka-wise analysis of the performance for the year 1993-94. Kindly study the

following table and comment on coverage levels in all the talukas of the district. How does it compare with reaction of the Ophthalmic Surgeons?

Block	Population (lakhs)	No. of operations (1993-94)
Tumkur	2.87	1643
Gubbi	2.32	334
Kunigal	2.12	239
Tiptur	1.60	374
Turuvekere	1.65	371
Chiknayahalli	1.76	340
Madhugiri	2.24	458
Pavagada	2.13	593
Sira	2.22	755
Korategere	1.46	339
TOTAL	23.06	5446

Do the same exercise for your own district after collecting the information in the enclosed format, prescribed by the NPCB for use within the district.

UTILIZATION OF THE RESOURCES

Most important of all the resources for NPCB in a district are the **Ophthalmic Surgeons (OSs)** due to the following reasons:

1. At present, cataract surgery can only be done by an OS.

2. There is very low availability of qualified OSs in rural districts.

On an average, an OS should do 700 cataract operations in a year (the actual numbers may vary widely, being higher for an OS in a mobile ophthalmic unit and lower for an OS in a medical college or private practice). The average output in a district can be estimated by dividing the number of cataract operations by that of OSs. This will give information about how efficiently the available OSs are being utilized for cataract surgery in a district.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS
BLOCKWISE MONITORING IN THE DISTRICT
(For use within the District)

State:———————— District————————————

Reporting Year: ☐☐-☐☐

CATARACT PERFORMANCE: Per 1000 popul.

BLOCK	POPULATION	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL
TOTAL														

EXERCISE 5

Given below are the number of available OSs and surgical output for cataract in 5 districts in India for the year 1993-94. Calculate the average output per OS in these districts and comment on the districts where the OSs are not being optimally utilized. What can be the reasons.

District	No. of OSs	No. of operations	Average output
Basti	7	2405	
Bhandara	8	4804	
Purnea	6	4003	
Salem	35	7126	
Tumkur	14	5446	

Estimate the average output of cataract surgery per OS in your district.

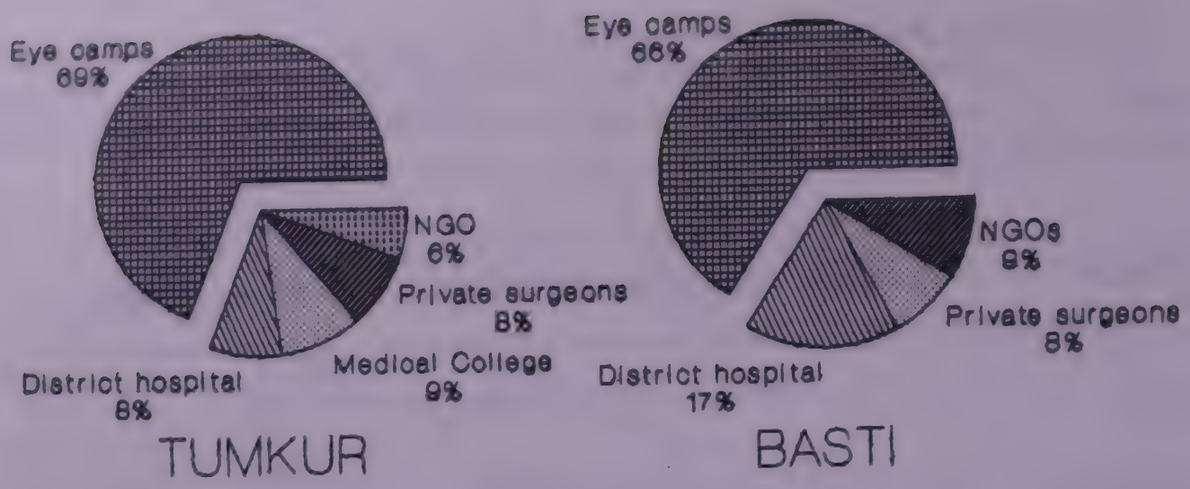
The next resource to be analysed is the availability and utilization of the **ophthalmic beds** in the district. The maximum output of cataract surgery in a year can be 52 per ophthalmic bed assuming that the bed is occupied round the year and a patient is kept for one week. But on an average, one ophthalmic bed should yield 40 cataract surgeries per year. An output below this should be considered as an indicator of underutilization of ophthalmic beds in the eye department.

EXERCISE 6

There are only 2 hospitals with eye beds in Basti district in Uttar Pradesh, namely the District hospital and the Sitapur Eye hospital with 10 and 54 eye beds respectively. During the years 1992-93 and 1993-94, 505 and 400 operations were done in the District hospital; whereas, in Sitapur Eye hospital, these figures were 295 and 216 respectively for the two years. Comment on how efficiently the eye beds have been utilized at the two hospitals after calculating the per bed output.

Estimate per eye bed output of the hospitals within your own district. What are the possible reasons for a low output, if any; and, how will you will like to solve this ?

Eye camps are still the major source of service delivery in India as can be made out from the following pie diagram, presenting the cataract surgery figures for Basti and Tumkur districts.



EXERCISE 7

Draw a similar pie diagram for your own district for the last year and compare it with the above two districts. What are your key observations. What decisions you will take to improve the situation in your district ?

Per camp output of cataract surgery is a good indicator of the productivity of the eye camps in the district. This type of analysis will demonstrate how efficiently the eye camps are being organized in a district. According to the NPCB norms, 50 operations (one OS operating) or 100 operations per eye camp per day (2 OSs operating) is the maximum expected outcome. On the other hand, an eye camp with less than 30 operations warrants a careful review. Therefore, an average of 40 operations per eye camp during the year is to be taken as a norm for good productivity by a mobile ophthalmic unit.

EXERCISE 8

In Basti district in Uttar Pradesh, during the year 1992-93, 136 eye camps were organized to do 1768 cataract operations. Next year, 1398 operations were done in 127 eye camps in the district. Comment on the efficiency of the mobile ophthalmic unit in conducting eye camps in Basti. If you're the DPM of Basti district, what 2 major decisions you will like to take ?

Do the same analysis for your district and record your key observations.

Yet another indicator that can be used to assess the efficiency of the eye camps is **Camp cancellation rate**. This is to be calculated as number of eye camps not organized at all or conducted with less than 20 cataract operations out of the total number of camps planned for the year.

EXERCISE 9

Calculate the camp cancellation rate in your district during the last year.

QUALITY OF SERVICES

You have noticed that all along in the previous chapters, the emphasis has been on quantitative aspects of evaluation. In relation to cataract surgery, of equal importance is the quality. For the patient, most important is the postoperative vision restored with aphakic glasses. For the programme, the outcome is in form of good surgery, least complications and provision of all services, the end point being dispensing (or prescription) of aphakic glasses after refraction. Compared to the simple parameters and quantifiable indicators described earlier, it can be easily realized that monitoring of the quality on an ongoing basis in cataract intervention is neither possible nor practical. There are two alternatives to tackle these bottlenecks:

1. Assessment of vision in the operated eyes in a district on a sample basis once a year or biennially. Unfortunately, no standard technique is available is at present to carry out this.

2. Introduction of standard patient records, wherein the postoperative visual acuity is recorded on a regular basis. The information retained with the hospitals, eye camp coordinators, NGOs and private OSs can be retired in the DPM's office for analysis. The final recorded visual acuity in the patient cards can be used to estimate the proportion of sight restoration. A common bottleneck is the poor follow-up by the patients operated in the eye camps, and the practice of dispensing +10 aphakic glasses on discharge is likely to continue for years to come. In this situation, proportion of the operated patients discharged with standard aphakic spectacles can be good measure of the quality of services. And alongwith with the proportion of patients (for whom the records are available) with good eyesight in the operated eyes (visual acuity 6/60 or better), it can give an overall impression about the effectiveness of the programme in the district.

Danida Support Unit, New Delhi is currently doing operational research on assessment of the quality of services, based on the above parameters, in the pilot districts. It is likely that a simple methodology will be made available for use by all the districts in the country by the beginning of 1996.

COMMUNITY BASED REHABILITATION

BHUSHAN PUNANI
NANDINI RAWAL

1. EXISTING SITUATION

The existing rehabilitation centres are few, confined to urban areas and cover a few hundred people in the working age group 16-35 years. Only 6 per cent blind children of school-age avail education facilities, whereas only 3 per cent blind persons of all age-groups avail rehabilitation facilities. On analysing the existing rehabilitation services, the following observations can be made:

1.1 Limited Coverage of the Target Group: The existing special schools in India, at present, cover only 12,000 visually handicapped children. The integrated education projects cover another 6,000 such children. Even if special education is extended to all blind children of the school going age (which is never going to be possible), the coverage would be only 3.2 per cent of the total population of the visually handicapped.

The existing vocational as well as on-the-job training centres at present cover a mere 2,500 visually handicapped persons. The existing trades are urban-oriented and do not necessarily lead to employment.

The schools and training centres cover the visually impaired in the age group of 5 to 35 years whereas the majority of the visually impaired population is in the age group of 45 years and above.

1.2 Least Preference to the Visually Handicapped: Most rehabilitation programmes which aim at providing comprehensive rehabilitation services to all categories of the disabled, mainly cover the locomotor handicapped only. In India, a variety of programmes like District Rehabilitation Centres Scheme (Ministry of Welfare), Project on Integrated Education of the Disabled (UNICEF), Integrated Education of Disabled Children (Ministry of Human Resource Development), Vocational Rehabilitation Centres (Ministry of Labour) have been launched for all categories of disabled but at present the major coverage under these programmes is that of the locomotor handicapped.

1.3 Lack of Social Security Measures: Most developing countries have not yet introduced social security measures for assuring a minimum standard of living for the disabled. Some state governments have introduced disability as well as old-age pension schemes. Due to limited budget allocation, cumbersome procedures, lack of public awareness, and lack of an effective delivery system, the coverage has been limited. A visually handicapped person is left at the mercy of family members and the community.

1.4 Higher Cost of Institutional Programmes: A research study reveals that the direct allocable per capita expenditure on integrated education is Rs. 2,229 which is less than one-fifth of the direct expenditure of Rs. 9,760 on residential education. Thus with the same resources, 9 students can be educated as compared to 2 of them under residential education. According to one estimate if all the children of school-age are to be imparted residential education, annual requirement of funds would be 300 crores per annum as compared to budget allocation of only 5 crores at present.

1.5 Only Viable Alternative: Keeping in mind the vast distribution of the visually handicapped in rural areas, the late on-set of visual handicap and the exorbitant costs of initiating and maintaining an institution, the inherent limitations of an urban based institution, the only viable alternative is a programme which can reach out and provide need based services to the visually handicapped of all age groups and yet be cost- effective.

Thus the only way of reaching out to the unreached persons in rural areas is to initiate and implement Community Based Rehabilitation Programmes (CBR) for the visually handicapped. For developing countries, the CBR is not a matter of choice but a compulsion. While components, implementation plan, monitoring procedures and level of community involvement in the CBR approach may be graded options - the CBR per se is the only alternative available at present to reach heretofore unreached millions of visually handicapped persons in these countries.

2. COMMUNITY BASED REHABILITATION

2.1 WHO Definition of CBR: "CBR involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and the handicapped persons themselves, their families and their community as a whole".

2.2 Modification of the Definition: In the context of developing countries, the characteristics of CBR can be modified. It should:

- be cost effective, individual need-based and result-oriented
- result into the complete integration of the individual into the community.

Once rehabilitated, a person should lead a more productive life, thus helping the community economically.

2.3 E. Helander's Description: Community-based rehabilitation is a strategy for enhancing the quality of life of disabled people by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights.

It calls for the full and co-ordinate involvement of all levels of society: community, intermediate and national. It seeks the integration of the interventions of all relevant sectors - educational, health, legislative, social and vocational - and aims

at the full representation and empowerment of disabled people. CBR should be sustained in each country by using a level of resources that is realistic and maintainable.

Referral services are needed to receive those disabled people who need more specialized interventions than the community can provide. The CBR system should seek to draw on the resources available both in the governmental and non-governmental sectors.

2.4 Outcome of CBR: The CBR should enable the individual:

(a) to stay within the fold of the family and contribute towards the family income.

(b) to function and perform as he used to function and perform prior to disability, that is restoring the fullest use of the senses to compensate for the loss of vision.

(c) prepare the community for the long term acceptance of the blind person and the self- propagation of his goal/mission

2.5 Extent of Coverage: From the experience of implementing a CBR programme exclusively for the visually handicapped persons at 85 locations in India, it has been established that a group of 8 field workers, 2 itinerant teachers and one supervisor can easily cover 360 visually handicapped persons in one block or tehsil within a period of two years.

It has also been established that the per capita cost of such services is less than Rs.1000 which is one-tenth as compared to institutional programmes. Thus CBR is the only alternative available at present for the comprehensive rehabilitation of the visually handicapped, particularly in developing countries. The components and methodology and coverage of CBR are different for different agencies.

3. COMPONENTS OF CBR:

Thus due to cost constraint, commonalty of services, scattered target group and state policy, it is essential that the CBR should:

- be exclusively for the visually handicapped
- cover persons of all age groups
- be cost effective and result oriented.
- be realistic and need-based
- include all aspects of:
  - i. prevention and cure of curable blindness
  - ii. certification of incurable blindness
  - iii. social integration
  - iv. integrated education
  - v. economic rehabilitation,

vi. support services and concessions
vii. advocacy for the rights of the blind
viii. acting as a pressure group for influencing state policies for the blind

3.1 Extent of Service Delivery:

The programme encompasses all aspects of prevention, cure, rehabilitation, integrated education, and support services. However, nature of services would vary with the type of target group as listed below:

A. For the general population:
   (a) Eye check-up
   (b) Child screening
   (c) Refraction
   (d) Public awareness
   (e) General health care

B. For curable blind persons:
   (a) Diagnosis
   (b) Eye treatment
   (c) Eye surgeries
   (d) Provision of glasses

C. For incurable blind persons:
   (a) Identification
   (b) Certification
   (c) Individual assessment
   (d) Individual counselling and family counselling
   (e) Provision of training in:
      (i) orientation and mobility
      (ii) activities of daily living
   (f) Social integration
   (g) Integrated education
   (h) Economic rehabilitation
      (i) Support services and concessions

3.2 Comprehensive Eye Care:

The term "comprehensive eye care" signifies provision of services of prevention of preventable blindness, cure of curable blindness, comprehensive rehabilitation, integrated education, support services, and creating public awareness about these aspects. The comprehensive eye care programme starts with identification of persons with eye problems- both curable and incurable and then working towards separation of both groups. Thus eye care and rehabilitation thus go hand in hand, both are simultaneous.

In case of community based rehabilitation, the major focus is comprehensive rehabilitation of incurable blind persons, and medical rehabilitation is incidental to

rehabilitation. In case of comprehensive eye care, all the services as listed above are provided as a comprehensive package. The target is providing all the services pertaining to medical, social and economical rehabilitation to the complete target population as a pre- planned package.

3.3 Methodology of CBR:

Based on the experience of implementation of such projects across the country, these components can be easily divided into direct as well as referral services as listed below. The field workers are required to handle direct services themselves and seek services of other specialists in case of referral. The details of the CBR functionaries required in the project are given in the points that follow.

1. The major direct services which are handled by the CBR team include:
   - (a) identification
   - (b) individual and family counselling
   - (c) social rehabilitation
   - (d) economic rehabilitation,and
   - (e) provision of support services.

2. The referral services in which case the beneficiary is referred to a specialist agency include:
   - (a) eye check-up
   - (b) certificate of blindness
   - (c) refraction
   - (d) eye treatment
   - (e) eye surgery, and
   - (f) integrated education.
   - (g) preventive, corrective and rehabilitative services for other categories of disabled persons.

In the case of medical rehabilitation and integrated education, the project implementing agency should confine its role to referral to the respective specialist agencies. The integrated education is handled by itinerant teachers by admitting children to accredited educational institutes, preferably in the same village. Similarly, the eye check-up, child screening, refraction, provision of low vision aids, eye treatment, eye surgery and cure activities are exclusively handled by the ophthalmic assistants, ophthalmologists, optometrists and such other specialists.

3. Referral for Other Categories of Disabled Persons: The Ministry of Welfare desires that community-based rehabilitation should cover all categories of disability simultaneously. The World Health Organization also advocates coverage of all categories of disability. Similarly the Ministry of Human Resource Development has also evolved the Central Scheme of Integrated Education of Disabled Children which envisages coverage of all categories of disabled children. The National Council for Educational Research and Training is also promoting multi-category approach of integrated education. It has already initiated multi-category teacher training.

While the programme should focus at comprehensive rehabilitation of visually impaired persons, it should provide referral services to other categories of disabled persons. Other disabled welfare organizations, health care agencies, ortho-prosthetic centres, vocational training institutes should be involved for this purpose.

a. Medical Rehabilitation: In case of locomotor handicapped, the corrective surgery and physiotherapy are the major inputs. In case of hearing handicapped, it is desirable to involve ENT specialists and Audiologist for the purpose of ENT check-up and audiometry respectively for exploring a possibility of correction of hearing handicap as well as improvement of hearing. It should be followed by the provision of suitable hearing aids and speech therapy.

b. Education and Rehabilitation: In case of locomotor handicapped, provision of ortho-prosthetic aids and appliances, rehabilitation aids like crutches, wheelchairs, tricycles etc. are the major inputs. As far as possible, such children with enhanced mobility should be educated in the regular schools.

The education of children with hearing handicap is a very complex process and requires staff with the specific qualifications. Unless such trained staff is available, one may in fact not be able to do proper justice to such children. The same logic would apply to children with mental retardation.

4. APPOINTMENT OF A PROJECT IMPLEMENTATION AGENCY

4.1 Need for Implementing Agency: The implementation of the project would require coordination at the block level in remote areas. It is not possible for any national or regional level urban based organization to implement such a project effectively without the involvement of local organizations. It is expedient to involve a local or block level blind welfare, rural development or health care organization to act as a Project Implementing Agency. The importance of having a local agency in command is that when the project funding is complete, this agency looks after the propagation of the project. Thus the principles of sustainability and permanency are fulfilled.

Our experience of implementing CBR projects in India reveals that it never advisable to depend only upon the blind welfare organizations for the implementation of such projects. The local level rural development organization, local hospitals and health care agencies and educational institutes have also proved very effective in this respect.

It is, however, essential that such local organizations should:

(a) seek active participation of the local administration
(b) have social acceptance of its existing programmes
(c) preferably have outreach programme
(d) have inclination to initiate and implement programmes for the disabled and
(e) have good relations with the local health care administration
(f) be a registered society or a charitable society
(g) be registered under Foreign Contribution Regulation Act.

4.2 Responsibilities: Such organization should be entrusted responsibility of initiation, administration, supervision and monitoring of the project at block level. The agency should be encouraged to involve local administrators, Govt. officials and other local opinion leaders in project implementation. It will enable the field functionaries to avail from the contacts of these persons while extending support services to the target group.

It is essential that such organization must consider and implement the CBR programme as its own programme. It must not consider itself an intermediary agency working on behalf of another regional or national level organization. Its other staff which is not working directly for the project should also have good understanding of the programme. It must also plan to integrate the CBR programme into its existing programmes. The technical expertise for training of staff and guidance in implementation would be provided by the central agency, details of which follow.

5. ROLE OF DISTRICT PROGRAMME MANAGERS:

The implementation of the activities under the National Programme on Control of Blindness has been strengthened by extending formation of the District Blindness Control Socities (DBCs) throughout the country. The objectives of the DBCs include identification and rehabilitation of all incurably blind persons in a block.

The District Programme Manager (DPM), a key functionary in the DBCs set up is expected to perform the following functions in respect of promotion of community based rehabilitation in the area of coverage:

5.1 Identify of a suitable project implementing agency as per the details given above.

5.2 Such agency should be assisted to avail financial assistance for the implementation of CBR project in the area. At present such assistance is available from the following sources:

(a) National Scheme of Assistance for the Rehabilitation of the Disabled: Under the scheme, 90 per cent grant-in-aid is available for the promotion of comprehensive rehabilitation of disabled persons of all categories, preferable in the rural areas.

Address: Joint Secretary
Ministry of Welfare
'A' Wing, Shastri Bhawan
New Delhi 110 001

Application for grant-in-aid under this scheme should be made to the State Department of Social Welfare for seeking their recommendation for grant-in-aid to the Ministry of Welfare.

(b) Central Scheme of Assistance for the Integrated Education of Disabled Children: Under the scheme, 100 per cent grant-in-aid is available for promoting integrated education of disabled children.

Address: Ministry of Human Resource Development
C, Wing, Shastri Bhawan
New Delhi.110 001.

The application under this scheme has to be routed through the Implementation Cell for the Integrated Education, generally constituted under the State Department of Education. The application has to be made in the prescribed proforma available from the Administrative Cell or the Ministry of Human Resource Development.

(c) Non-Government Funding Agencies: Project based assistance for the promotion of comprehensive eye care or Community Based Rehabilitation is also available from the following Funding Agencies:

1. Sight Savers - Royal Commonwealth Society for the Blind
A-3 Shivdham Cooperative Housing Society
Plot No. 62, New Link Road, Malad (West)
Bombay 400 064.

2. Christoffel Blindenmission
South Asia Regional Office
1, Highway Colony
Tiruchirapalli-620 020
Tamilnadu.

3. DANIDA Assisted National Programme for
Control of Blindness (DANPCB)
A-148 Safdarjung Enclave
New Delhi 110 029 Phone: 6881909 6881099

4. OXFAM
III Floor, E-15 Haus Khas Market
New Delhi 110 003

5. South Asia Partnership (India) SAP
   C. G. I Floor, Commercial Complex
   Safdarjang Development Area,
   New Delhi

6. MISEREOR
   C/O Indo-German Social Service Society
   28, Lodhi Road, Institutional Area
   New Delhi 110 001

7. National Association for the Blind
   11 Khan Abdul Gaffar Khan Road
   Worli Seaface, Bombay 400 025
   (a) NAB Rural Activities Committee for rehabilitation
   (b) NAB Education Committee for integrated education

8. State Bank of India
   Community Banking Services Scheme
   Nariman Point, Bombay

9. Helpage India
   TRDC C-14, Qutab Institutional Area
   South of IIT, New Delhi-110 016.

The District Programme Manager (DPM) may help the respective non-governmental organizations for seeking assistance from these Funding Agencies. The list of Agencies is not exhaustive, there may be other Funding Agencies who would be willing to extend financial assistance for this purpose.

The District Programme Manager (DPM) should make a list of other funding agencies operating in the District or in the State. He should approach such agencies for exploring the possibility of seeking financial assistance for the promotion of community based rehabilitation of the incurable blind persons in the area.

5.3 Co-Option of the Project Implementing Agency on the District Blindness Control Society.

The District Programme Manager (DPM) should propose the Governing Council of the District Blindness Control Society to appoint a representative of the CBR Programme Implementing Agency as a Member of the Society. There is already provision as per section 1.51 of the Guidelines for the District Blindness Control Society to consist one representative from local Voluntary Action Group as a Member of the Governing Council.

By taking such representatives, the DPM would be able to seek cooperation of the CBR Project Implementing Agency to function in coordination with the DBCs for the promotion of Community Based Rehabilitation in the area.

5.4 Assisting in Training of the Field Staff:

As mentioned in paragraph 6.3, the training of field staff would constitute preliminary information about eye care, physiology and anatomy of eye, causes and symptoms of visual impairment and introduction to low vision aids. The DPM may extend services of the ophthalmic team for conducting this component of training.

The DPM should preferably attend the inaugural function for the training programme, conduct a few lectures on explaining the role of DBCs in programme implementation. In this way he would be able to establish functional relations with the field team which would enable close cooperation between the DBCs and the field team.

5.5 Involvement of Field Team in the Screening Camps:

The DPM should extend services of the Ophthalmic Team for conducting Screening Camps in the project area. As mentioned in paragraph 4.2, the curable blind persons would be extended further services of refraction, treatment and surgery by the DBCs. Whereas the incurable blind persons would be imparted services of comprehensive rehabilitation as per CBR process mentioned in paragraph 4.

5.6 Certification of Blindness:

The DPM would extend fullest cooperation in respect of providing certificates of blindness to the incurable blind persons. In certain States such certificates are to be countersigned by the Civil Surgeon. The DPM would extend his cooperation for enabling the project implementing agency to avail such services.

5.7 Monitoring and Control:

The DPM would also assist the Project Implementing Agencies in the monitoring and control of the CBR programme. He should participate in the weekly review meetings to understand difficulties of the field team and to assist them in solving their problems pertaining to ophthalmic aspects of the implementation plan.

5.8 Conclusion:

In short the District Programme Manager would extend fullest cooperation in the implementation of the comprehensive programme. He would be responsible for maintaining functional and systemic linkages between the CBR Programme Implementing Agencies, DBCs and the State as well as Central Governments. While the implementation of the project would be completely carried out by the Project Implementing Agencies, the District Programme Manager would extend full cooperation and support to such agencies in promotion of services for the incurable blind persons.

Printed at : Power Printers, 2/8 A, Ansari Road, Darya Ganj, New Delhi-110002
Phones : 3272445